Dear Patient,

We are pleased to welcome you as a new patient. It is our mission to provide you with comprehensive and compassionate health care. If you need to cancel or reschedule your appointment, please call our office 24 hours in advance at 203.431.1688.

During your initial evaluation, Dr. Sousa will develop a personalized treatment plan for you. Your plan may include lab tests, a physical exam, nutritional supplements, botanical medicines, or lifestyle changes. At the end of your session Dr. Sousa will ask to see you again for a follow up 2-6 weeks after your first appointment.

It may take a few office visits to find the appropriate protocol for you, and for you to start feeling better. It is important for you to realize the commitment and effort needed to achieve your potential.

This packet contains all the paperwork you need to get started. Fill out everything prior to your appointment. If you have any questions call the office at 203.431.1688.

Please bring all of your prescription medications, over the counter medications, and all and any supplements you are taking to your first appointment.

Please bring any lab reports, imaging, or other tests you have done in the last 2 years to your appointment as well.

Dr. Sousa looks forward to meeting with you!

Naturopathic Healing
DR. STEPHANIE SOUSA

General Information: Today's Date: _____

Patient Name: _____ DOB: _____ Age: _____ Sex: M F

Address: _____City: _____ State:____ Zip code: _____

Please select/fill in appropriate forms of communication:

□ Home telephone: _____ □ Work telephone: _____

□ Cell/Mobile: _____ □ Email: _____

In the event you do not answer your contact phone number, Dr. Sousa

□ May leave a message with your voicemail service □ May not leave a message.

Emergency Contact: _____ Relation: _____ Phone: _____

Have you seen a naturopathic physician before?: □YES □NO When?_____ Name of ND:_____

How did you hear about Dr. Sousa?:_____

Insurance Information:

Insurance Company: _____ Primary Insured: _____ DOB:_____

Relationship to Patient: _____Insurance ID #: _____ Group #: _____

Assignment and Release: I hereby authorize and direct my insurance benefits to be paid directly to Naturopathic Healing. I also understand that I am financially responsible for any and all non-covered services provided to me by Naturopathic Healing. I authorize the use of my signature on all insurance submissions. Dr. Sousa may use my health care information and may disclose such information to the above- named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

_____

Patient/Guardian Signature

Do you have a primary care physician?: □YES □NO Name of PCP: _____ Phone Number: _____ Can Dr. Sousa contact this provider?: □YES □NO	Are you seeking adjunctive Cancer support?: □YES □NO Name of Oncologist: _____ Phone Number: _____ Can Dr. Sousa contact this provider?: □YES □NO

Reason for your visit: _____

_____

When did this condition/symptom start?: _____

How much change are you willing to make to improve your health?: ___Minimal ___Some ___Complete

How would you rate your health today?: ___Poor ___Fair ___Good ___Very Good ___Excellent

Do your health concerns interfere with your: ___Work ___Daily Routine ___Sleep ___Family Life ___No interference

Have you lost time from work or school in the past year due to your health concerns?

___None ___1-2 Days ___3-14 days ___More than 15 days

What expectations do you have for your visit today?: _____

_____

When was the last time you felt really well?: _____

Medical History:

Date of last physical examination: _____ Reason for visit: _____

List all prescription and over the counter medications and supplements you take and their dose:

_____ _____

_____ _____

_____ _____

_____ _____

List all allergies to the following and describe the reaction:

Medications:_____

Foods:_____

Environmental:_____

List any hospitalizations with approximates dates and reason: _____

_____

List any surgeries with approximates dates and reason: _____

_____

List any recent (last 3 years) exams/imaging including approximate date and result (X-Rays, MRI, CT Scan, EKG, EEG, bone density scans, mammograms, colonoscopy, ultrasound etc): _____

_____

Describe any major losses, violence, traumas or accidents you have experienced: _____

_____

List all past and current medical diagnoses: _____

_____

Have you ever had a psychiatric diagnosis? (When and what): _____

Have you ever taken antibiotics?: □Yes □No

If yes, when was the last time you took antibiotics and for how long?: _____

If yes, how often have you taken antibiotics?:

Infancy & childhood:	___Less than 5 times	___More than 5 times	___Unsure
Teen:	___Less than 5 times	___More than 5 times	___Unsure
Adulthood:	___Less than 5 times	___More than 5 times	___Unsure

Childhood illness (Check off any that you had, add approximate date/age): ___Rubella (German measles)

___Measles	___Mumps	___Chicken pox	___Roseola	___Asthma
___Polio	___Whooping cough	___Diphtheria	___Scarlet fever	___Eczema
___Rheumatic fever	___Ear infections			

Check off which, if any immunizations you have received: ___Unsure, probably all of them

___Hep B	___Rotavirus	___Diphtheria/tetanus/pertussis (DTap)		___Hib
___Pneumococcal	___Polio	___Influenza	___Measles/mumps/rubella (MMR)	
___Varicella/chicken pox	___Hep A	___Meningococcal	___HPV	___Other:_____

___COVID-19: Brand and Dates_____

Did you have any adverse effects or reactions from any immunizations?: □Yes □No □I don't know

If yes, please explain:_____

Your birth:

Were you born: ___Naturally ___C-section ___I don't know

Term: ___Full term ___Premature ___Late term ___I don't know

Were you breastfed? □Yes □No □I don't know

If yes, for how long?: _____ If no, what was the source of nutrition?: _____

Any significant complications during the pregnancy/delivery?: _____

What is your blood type: _____ □Not Sure?

Diet History:

Foods/food groups avoided: _____ Why?: _____

Food cravings: _____

Number of meals eaten a day: _____ Number of meals eaten out a week: _____

What have you eaten in the last 24 hours?:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Cups Water/day:_____ Alcoholic Drinks/week: _____Coffee/caffeinated beverages/day: _____

What is your biggest challenge to buying, preparing and eating healthy foods?: _____

_____

Do you have symptoms within 1-2 hours of eating? (belching, bloating, sneezing, etc): □Yes □No

If yes, describe what happens and after which kinds of foods/meals: _____

_____

Do you have delayed (24 hours+) symptoms after eating certain foods?: □Yes □No

If yes, describe the symptoms, approximate amount of delayed time, and food(s) associated with this:

_____

Do you have *any* history of food poisoning? If yes, describe approximately when: _____

How often do you have a bowel movement? _____

What is the consistency of your bowel movement? ___Soft & well formed ___Difficult to pass ___Loose

___Diarrhea ___Alternating Other:_____

Sleep History

What is the typical time you go to bed and wake up?: _____

How would you rate your sleep?: ___Poor ___Fair ___Good ___Very Good ___Excellent

How long does it take you to fall asleep?: _____

Do you feel rested in the morning?: □Yes □No □Sometimes

Do you suffer from insomnia?: □Yes □No □Sometimes

If yes, What keeps you up at night?: _____

Do you use medications or natural substances to help you fall asleep?: □Yes □No

If yes please describe what you use and how often: _____

Do you experience frequent dreams or nightmares?: _____

What position do you sleep in?: _____

Social History:

Check one: ___Single ___Married (how long) ___Divorced (When) ___Widowed (When)

Other: _____

Do you have any history of abuse? □Yes □No

Children, if any: Names and ages: _____

Occupation/Hours worked per week: _____

What is your highest education?: ___Middle School ___High School ___College ___Graduate School

With whom do you live with?: _____

How would you describe your mood?: _____

What triggers changes in your mood?: _____

On a scale from 1-10 how is your stress on a typical day? (Circle one answer):

No stress what so ever 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Extremely over whelmed

What triggers your stress?: _____

How do you cope with stress?: _____

On a scale from 1-10 how is your energy on a typical day? (Circle one answer):

No energy 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Very energetic

Exercise?: □Yes □No □ Sometimes Types: _____ Frequency: _____

Do you smoke?: □No, never □Yes, I smoke _____ cigarettes a day for _____years.

How many times have you attempted to quit?: _____

□Former smoker: cigarettes a day: _____ years: _____ quit: _____

Do you use recreational drugs? □Yes □No If yes, what and how often?: _____

Do you have any pets or farm animals?: □Yes □No If yes, please describe: _____

Are you spiritual or religious?: □Yes □No Religion:_____

Does your religion have any specific dietary requirements?: _____

Do you have any problems swallowing pills or capsules?: □Yes □No

In the last 3 years have you traveled out side of the US?: □Yes □No

If yes, to where and when: _____

Have you or do you serve in the military?: □Yes □No If yes where and when?: _____

What do you enjoy most in life?: _____

What are your hobbies?: _____

Do you take vacations?: □Yes □No _____

Do you watch TV? □Yes □No If yes, how many hours/day?: _____

Environmental

Which of the following might have you been exposed to:

___Non-stick/Teflon Cookware	___Pesticides		
___Mercury /other metals	___Garden chemicals	___Aluminum cookware	___Mold
___Toxic fumes/chemical	___Second hand smoke	___Dry cleaning chemicals	___Solvents-
___Well	___City Water	___Bottled Water	___Other _____

Do you use a water filter?: □Yes □No

Family History: List if any family members that have/have had: diabetes, stroke, heart attack, Alzheimer's disease, high blood pressure, high cholesterol, cancer (type), gastrointestinal disease, alcoholism, skin disease, thyroid problems, mental illness, genetic disorders and any other significant health conditions.

	Age if alive	Age at Death	Health problems/cause of death
Mother	_____	_____	_____
Father:	_____	_____	_____
Sisters:	_____	_____	_____
	_____	_____	_____
Brothers:	_____	_____	_____
	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
Maternal Grandmother:	_____	_____	_____
Grandfather:	_____	_____	_____
Paternal Grandmother:	_____	_____	_____
Grandfather:	_____	_____	_____

Review of Systems: Check all that apply to you currently

GENERAL	**HEAD/NECK**	**EYE**	**EAR/NOSE**
☐ Chills	☐ Brain fog/memory loss	☐ Cataracts	☐ Earache
☐ Fatigue	☐ Goiter/enlarged thyroid	☐ Blurred vision	☐ Ear discharge
☐ Fever	☐ Hair loss	☐ Double vision	☐ Excessive earwax
☐ Light-headedness	☐ Headaches	☐ Eye tearing	☐ Ear infection
☐ Loss of sleep	☐ Head Injury	☐ Eye dryness	☐ Hay fever/allergies
☐ Night Sweats	☐ Migraines	☐ Glaucoma	☐ Hearing loss
☐ Numbness	☐ Pain or stiffness in neck	☐ Glasses/contacts	☐ Nosebleeds
☐ Weight loss or gain	☐ Poor concentration	☐ Visual floaters	☐ Ringing in the ears
Other:_____	☐ TMJ problems/jaw clicks	Other:_____	☐ Sinus infection
	☐ Swollen glands		☐ Stuffy or runny nose
	Other:_____		Other:_____

MOUTH/THROAT	CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL
☐ Bad breath ☐ Bleeding gums ☐ Cold sores ☐ Difficulty swallowing ☐ Dry mouth ☐ Fillings ☐ Hoarseness ☐ Root canal ☐ Tonsils removed Other:_____	☐ Anemia ☐ Arrhythmia/murmur ☐ Blood clots ☐ Chest pain ☐ Cold hands/feet ☐ Deep leg pain ☐ Easy bruising ☐ Palpitations ☐ Heart disease ☐ High cholesterol ☐ High blood pressure ☐ Low blood pressure ☐ Swelling in hands/feet ☐ Varicose veins Other:_____	☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Pain with breathing ☐ Persistent cough ☐ Pneumonia ☐ Shortness of breath ☐ Sputum ☐ Wheezing ☐ Coughing up blood Other:_____	☐ Abdominal pain ☐ Blood in stool ☐ Change in appetite ☐ Constipation ☐ Diarrhea ☐ Eating disorder ☐ Foul odor in stool/gas ☐ Gas/Bloating/Belching ☐ Gallbladder disease ☐ Hemorrhoids ☐ Ingestion/heartburn ☐ Liver disease ☐ Nausea/vomiting ☐ Ulcer Other:_____
GENITO-URINARY	**ENDOCRINE**	**NEUROLOGIC**	**MUSCULOSKELETAL**
☐ Blood in urine ☐ Change in urine odor ☐ Decreased stream ☐ Frequent urination ☐ Frequent UTI ☐ Incontinence ☐ Kidney Stones ☐ Painful urination Other:_____	☐ Excessive Thirst ☐ Excessive Hunger ☐ Hypothyroid ☐ Hyperthyroid ☐ Low blood sugar ☐ PCOS ☐ Metabolic syndrome Other:_____	☐ Anxiety ☐ Depression ☐ Dizziness/vertigo ☐ Fainting ☐ Nervousness ☐ Loss of balance ☐ Loss of coordination ☐ Seizures/epilepsy ☐ Suicidal thoughts Other:_____	☐ Gout ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Muscle pain/weakness ☐ Osteoporosis/ osteopenia ☐ Paralysis/weakness Other:_____
SKIN	**MALE CONDITIONS**		
☐ Acne ☐ Brittle nails ☐ Dandruff ☐ Eczema ☐ Hives ☐ Nail fungus ☐ Psoriasis ☐ Rash ☐ Sores/ulcers Other:_____ _	☐ Breast lumps ☐ Difficulty with erections ☐ Ejaculation problems ☐ Libido changes ☐ Lump in testicles ☐ Pain with intercourse ☐ Penile discharge ☐ Sore penis Other:_____ __ ***Dates of last***: Prostate exam: _____	**CURRENT:** HEIGHT:_____WEIGHT:_____	

FEMALE CONDITIONS □ Abnormal PAP smear □ Bacterial vaginosis □ Breast changes/pain □ Endometriosis □ Heavy or excessive flow □ Herpes □ Hot flashes □ Infertility □ Lack of menses □ Loss of libido □ Mid-cycle bleeding □ Menstrual clotting □ Nipple discharge □ Pain with intercourse □ Painful menses □ PMS symptoms □ Vaginal discharge □ Vaginal dryness □ Vaginal pain □ Yeast infection Other:_____	Do you perform self-breast exams? □Y □N How often?: _____ Age of menarche:_____ Duration of bleed: _____ Are cycles regular? □Y □N Length of cycle: _____ Age of last menses:_____ Are you pregnant?: _____ Total# of pregnancies: ___ Total# vaginal births: _____ Total# C-sections:_____ Total# of miscarriages:____ Total# of abortions:_____ Number of children: _____ Currently breast-feeding? □Y □N Are you taking any hormones or birth control pills?: _____ Do you use tampons? □Y □N ***Dates of last***: Menstrual period _____ PAP smear: _____ Mammogram or Thermogram: _____	

Is there any other information you would like to add?: _____

_____

Thank you for your time to provide me with this information! Please bring any supplements and medications you are taking as well as any recent laboratory reports to your appointment.

To my knowledge I have filled out the above form with information that is accurate and complete. I understand that it is my responsibility to inform the physician in charge of my care if I ever have a change in health.

_____ _____

Patient Signature Date

Informed Consent for Treatment

I, _____, consent to be treated by Dr. Sousa. The following common modalities may be used: diet changes, nutritional supplements, botanical medicine, homeopathy, hydrotherapy, physical medicine and lifestyle counseling. Dr. Sousa will take a thorough case history, do pertinent physical examinations, and may order labs and or imaging.

Please inform Dr. Sousa of any disease that you are suffering from, if you are on any prescription or over the counter medications, if you are pregnant, suspect you are pregnant or are breast-feeding. Even the gentlest therapies may have complications in certain conditions such as pregnancy and breastfeeding, in very young children, the elderly, or those on multiple medications. The slight health risks associated with naturopathic medical treatment include, but are not limited to: aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain, bruising or injury from venipuncture, risks and side effects associated with supplements, inconvenience of lifestyle changes, and possible prescription drug interaction with prescribed natural supplement or product

I understand Dr. Sousa will answer my questions to the best of her ability and results are not guaranteed. I do not expect Dr. Sousa to be able to anticipate and explain all risks and complications. I will rely on Dr. Sousa to exercise judgment during the course of the treatment which she feels at that time is in my best interests, based on the facts then known. Initials _____

Services received at Dr. Sousa's office are supplementary care to my primary care physician (PCP) and/or specialist's treatment. It is recommended that I consult with my PCP and/or specialist to obtain information about all of the conventional medical treatment options available to me. Initials _____

I understand that Dr. Sousa does not recommend abruptly stopping or tapering down of prescriptive medications without the supervision of the prescribing medical doctor as this can cause serious, if not life threatening, consequences. Initials _____

I understand that the treatments provided or recommended by Dr. Sousa may be different from those offered by another licensed health care providers, and that I am at liberty to seek other care. I assume the responsibility for the decision to take any natural remedy and will not hold Dr. Sousa liable for any side effects or interactions that arise from taking any naturopathic medicines while taking concurrently or not, any and all prescriptive and over the counter medications and if I feel I am having any adverse reaction, to stop taking all supplements immediately. Initials _____

By signing below I hereby certify that I have read this entire form, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment performed for my present condition and for any future condition(s) for which I seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

_____ _____

Patient/Guardian Signature Date

Authorization and Consent to Participate in Telemedicine Consultation

Purpose and Benefits: Advances in technology have results in new approaches to providing medical care. Live real-time audio/video communication through interactive technology that enables a patient and doctor who are separated by distance to interact simultaneously. This is referred to as telemedicine. The benefits of telemedicine include facilitating care to patients unable to attend office visits in person, reducing the expenses of traveling to see a physician and expanding patients' accessibility to healthcare services.
This form is intended to obtain your consent to participate in telemedicine consultations with Stephanie Sousa Cardoso ND.

Residence within Connecticut is required for telemedicine consultations with Dr. Sousa Cardoso. Residence will be verified prior to scheduling appointments. Some states or insurance plans place restrictions on where the patient can receive virtual care.

This service is only available to established patients. First office visits must be an in-office (face- to –face) appointment.

In-office appointments are required once a year.

Risks and Consequences: Some people find telemedicine difficult or uncomfortable initially. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Not all patient situations will be appropriate for telemedicine. Following your telemedicine consultation, Dr. Sousa may recommend an in-office visit, or a visit to a hospital, urgent care, or your primary care doctor for further evaluation.

Confidentiality: Reasonable and appropriate efforts will be made to eliminate any confidentiality risks associated with the telemedicine consultation. To maintain your privacy, it is recommended that you use headphones, meet in a private area, and do not share any log in credentials with anyone.

Medical Records and Health Information: All existing confidentiality protections under federal Connecticut state law apply to information disclosed during the telemedicine consultation (HIPAA- Health Insurance Portability and Accountability Act of 1996). All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

Rights: You may withhold your right or withdraw your consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risk of the loss or withdrawal of any insurance program benefits of which you would otherwise be entitled. You have the option to consult with Dr. Sousa Cardoso in person if you travel to her office at 10 South Street. Suite 205, Ridgefield, CT 06877.

Nature of the consultation: The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with Dr. Sousa at a distance. During this telemedicine consultation, details of you and/or your child's medical history, examination, imaging results, and/or lab tests will be discussed through the use of interactive video, audio and telecommunication technology. Non-medical technical personnel may be present in the telemedicine location to aid in the video transmission. Individualized,

integrative treatment plan is discussed. *Dr. Sousa Cardoso does not use a platform that records the consultation.* Dr. Sousa Cardoso will make notes on the consultation in your medical record.

Financial Agreement: You and/or your insurance company will be billed for this visit. Please see separate office policies

I _____have been advised of some of the potential risks, consequences and benefits of telemedicine. My healthcare provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

_____ _____

Patient/Guardian Signature Date

_____

Relationship to Patient

Credit Card Consent Form

I, _____, give Naturopathic Healing LLC permission to charge my credit card (specified below) for services rendered, late appointment fees, cancelations fees, missed appointment fees, laboratory fees, supplement purchases, shipping and handling fees and/or other charges incurred during treatment.

This agreement commences on _____ (Today's date)

This agreement includes charges for services rendered to:

☐ Myself

☐ Other (as indicated below)

Type of card: ☐Mastercard ☐Visa ☐Discover ☐American Express

Name on credit: _____

Number on card: _____

Expiration date: _____

Validation code: _____

Billing Zip code: _____

By signing this document, I am in agreement with Naturopathic Healing policies:

- Payment is due at time of service
- Account balances for services rendered will be charged to the credit card listed above. If another form of payment is desired, it must be provided at the time of scheduled appointment.
- If the credit card on file is lost, stolen, compromised, or canceled, the patient is responsible for informing Naturopathic Healing and providing an additional form of payment.
- Naturopathic Healing will not release credit card information or charge for services not provided without permission from the patient.
- Dr. Sousa requires at least 24 hours notice for cancellation of my scheduled appointment and cancellations with less than 24 hours notice will be charged a **25$** late cancellation fee. Missed appointment will be charged a missed appointments fee of **50$**.

Signature: _____ Today's Date: _____

This form acknowledges your receipt of the **Notice of Office Policies** and the **Notice of Privacy Practices** and will be retained in your medical record.

*I have received the **Notice of Office Policies** and have been provided an opportunity to review it.* Initials _____

I, _____ hereby authorize Dr. Sousa and affiliates, employees, and agents to release health information except the following _____ (any information not to be disclosed), for the purposes of treating, billing, resolving claims, health benefit coverage issues, as stated above. This authorization is valid from the date of my signature below and shall expire on _____(Date). I understand that this authorization is voluntary and that I have the right to refuse to sign it. I understand that my refusal to sign will not affect my eligibility or benefits for coverage of service. I understand that I have the right to cancel this authorization by providing a written notice to Dr. Sousa and that any action taken by Dr. Sousa, its employees, or agents prior to receiving my written notice cannot be revoked.

*I have received copy of the **Notice of Privacy Practices** and I have been provided an opportunity to review it.*

_____ _____
Patient/Guardian Signature Date

_____
Relationship to Patient

Notice of Office Policies

Financial Policy: I accept full responsibility for any fees incurred during treatment and I understand that payment is expected in full at time of service. Accepted forms of payment include cash, personal checks, and credit cards. There is a 30$ fee for bounced checks. I may request the fees for various procedures before they occur to include that information in my healthcare decision-making process. I understand that telemedicine consultations are billed the same as in office appointments.

Credit Card on File Policy: Naturopathic Healing LLC will require you to leave a credit card on file at the time of your initial visit for services rendered, late appointment cancelation fee, missed appointment fees, laboratory fees, supplement purchases, shipping and handling fees and /or other charges. I understand that my information will be saved on file for future transactions on my account. Effective May 1, 2021: New patients who have rescheduled their new patient visit more than two (2) times will be required to leave a refundable deposit in the amount of $50. This deposit will be collected via credit card over the phone and then refunded to your credit card (or applied to your account if the patient would like) at the first office visit.

In Network Insurance: Dr. Sousa currently participates with Anthem BCBS, Cigna, Connecticare, First Health Network, Husky (for children under 21), Oxford and United Health Care. It is the patient's responsibility to ensure coverage. Accurate and complete information is required at your first visit. If you have a co pay, you are required to make payment at the time of service. If your policy requires a deductible or co-insurance the patient is responsible for paying in full at each visit.

Insurance Changes: If your insurance changes during the course of treatment, you must provide this information prior to being seen at your next appointment. Many insurance companies require authorization that will not be backdated for any reason. If there is a time lapse between the effective date of your new policy and informing the clinic of your new insurance company you will be responsible for any claims that are denied for any reason including lack of referral and/or authorization.

Out of Network Insurance: If we do not participate with your insurance company, you will be responsible for payment in full at the time of service.

Medicare & Medicaid: Medicare & **Medicade (for adults) do NOT** recognize naturopathic medicine. Both insurance companies will **NOT** cover any appointments or supplements. If the patient has a secondary insurance company that will provide coverage, it the patient's responsibility to submit all claims. Dr. Sousa will provide the patient with all necessary codes and information.

No Insurance: If you are not insured, or your insurance company will not cover naturopathic services, you will be considered a self-pay patient. Self-pay patients are required to pay in full at each visit.

Payment Fee Schedule for Self-Pay Patients 2022

Homeopathic Consultation (90-120 mins)	295	Return Office Visit Continuing Care (20-29)	95
First Office Visit Establishing Care (60-74 mins)	195	Return Office Visit Continuing Care (10-19)	85
First Office Visit Establishing Care (45-59 mins)	195	Blood Draw/Finger Prick (15 mins)	25
First Office Visit Establishing Care (30-44 mins)	175	Constitutional Hydrotherapy (30-45 mins)	75
First Office Visit Establishing Care (15-29 mins)	95	Contrast Hydrotherapy (15 mins)	25
Return Office Visit Continuing Care (40-54 mins)	95	Single remedy	6
Return Office Visit Continuing Care (30-39)	95	Combination remedy	12

Notice of Office Policies

Tardiness Policy: I understand that a late arrival may be subjected to an abbreviated visit charged at the full visit fee.

Missed Appointment/ Cancelation Policy: I am aware that Dr. Sousa requires at least 24 hours notice for cancellation of my scheduled appointment and cancellations with less than 24 hours notice will be charged a **25$** late cancellation fee. If you miss an appointment you will be charged a missed appointments fee of **50$**. This payment is expected before any further treatment will be rendered. *This is a patient responsibility and will not be billed to your insurance company.*

Senior/Student Discount: Naturopathic Healing gives a 10% discount on office visits and supplements to all self pay seniors over the age of 65 and all self pay students with a valid student ID. The discount will not be applied to the initial visit, but will be applied to return office visits and supplements purchased through the online dispensary.

Email Policy: Email is only used for established patients in non-emergent situations, for clarification of ongoing treatment or treatment received in the last 30 days. No new health concerns will be addressed via email. If Dr. Sousa receives an email about a condition that in her opinion cannot be properly assessed without an office visit, the patient will be notified by return email to schedule an appointment. In this case, no treatment advice will be given by email. Dr. Sousa will respond to emails within 24-48 hours, Monday through Friday only. If you have emailed Dr. Sousa and have not received a response within these parameters please call the office and leave a message stating your question or concern. Please keep in mind that communications via email over the Internet are not secure and Dr. Sousa does not use an encrypted email. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. By emailing Dr. Sousa you acknowledge that you are comfortable with having an email relationship with Dr. Sousa knowing that Dr. Sousa's email is not encrypted. If you do not wish you use email as a form of communication, please call the office when you have a concern to schedule an appointment.

Supplement Policy: All supplements are priced individually. **All sales are final.** No refunds, credits or exchanges are allowed on supplement(s), herb(s), homeopathic remedy/remedies, vitamins and nutritional supplements dispensed in office. Once these items have been shipped, purchased or left the office they cannot be brought back under any circumstance. All containers and bottles are inspected when they come in and leave the office for integrity of all safety and health seals. I understand that all supplements, vitamins, medical grade food, nutritional powders, botanicals, homeopathic remedies, and cell salts are not covered by insurance. For all items purchased through the online dispensary, please refer back to their return/exchange policy.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to Dr. Sousa. She understands that your medical information is personal and is committed to protecting it. She keeps a record of the care and services you have received to provide you with quality care and to comply with certain legal requirements.
The federal Health Insurance Portability and Accountability Act (HIPPA) of 1996 states the following:
You have rights to:

- Receive a copy of your health information
- Correct your medical records if you believe that some information of your health is incorrect or incomplete
- Request confidential communication by asking Dr. Sousa to contact you via a specific way: email, cell phone, mail.
- Ask Dr. Sousa to not use or share certain health information about you for the purposes of treatment, payment, or operations.
- Get a list of whom Dr. Sousa shared your health information with, date shared, and why.
- Get a copy of this privacy notice.
- Choose someone to represent you: parent, legal guardian, or someone whom you've given medical power of attorney.
- File a complaint if you feel that your privacy rights have been violated. You can file with the US Department of Health and Human Services Office for Civil Rights:
  200 Independence Avenue, S.W. Washington, D.C 20201.
  Or call 1-877-696-6775. Or visit: www.hhs.gov/ocr/privacy/hipaa/complaints/

You have a choice to:

- Allow Dr. Sousa to share information with your family, close friends, and other's involved in your care.
- Allow Dr. Sousa to share your health information in a disaster relief situation
- Allow Dr. Sousa to include your information in a hospital directory.
- *If you are unable to tell Dr. Sousa your preference, for instance if you are unconscious, she may go ahead and share your information if she believes it is in your best interest, or if your health and safety is in imminent threat.*

In the following cases, your information is never shared without written permission to do so:

- Marketing,
- Sale of your information
- Sharing of psychotherapy notes
- Fundraising

Our Uses and Disclosures of your information:
Dr. Sousa is allowed to use and share your information in the process to: treat you, run her facility, bill for your services, help with public health and safety issues, do health research, comply with the law, respond to organ and tissue donation requests, work with a medical examiner or funeral director, respond to lawsuits and legal actions, and to address worker's compensation and other governmental requests.

Dr. Sousa is required by law to maintain privacy and security of your protected health information, and will let you know promptly if breach of privacy occurs. She will not use or share your information other than as described above, unless you tell her in writing. If you change your mind at any time, please let her know in writing.

Changes to the Terms of This Notice: Dr. Sousa can change the terms of this notice and the changes will apply to all information she has about you. The new notice will be available upon request, in office.