Naturopathic Healing
DR. STEPHANIE SOUSA

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

Pediatric General Information Today's Date: _____

Child's Name: _____ Sex : □M □F DOB: _____Current Age: _____

Address: _____City _____ State:_____ Zip code:_____

Are you the child's: □Mother □Father □Grandparent □ Other: _____

Besides you, does anyone else care for the child? □NO □YES, Who?:_____

Parent 1: □Mother □Father □Guardian _____ Age:_____

Address: _____City _____ State:_____ Zip code:_____

Email:_____ Cell Phone: _____ Home Phone: _____

It is ok to leave a message on: □Home # □Cell #

Parent 2: □Mother □Father □Guardian _____ Age:_____

Address: _____City _____ State:_____ Zip code:_____

Email:_____ Cell Phone: _____ Home Phone: _____

It is ok to leave a message on: □Home # □Cell #

Child's Emergency Contact: _____Relation: _____ Phone: _____

Has your child been seen a naturopathic physician before?: □YES □NO When?_____ Name of ND:_____

How did you hear about Dr. DeSousa? _____

Child's primary pediatrician: _____ Phone: _____

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

Reason for your visit: _____

_____

When did this condition/symptom start?: _____

How does your child's condition affect him/her?: _____

What do you feel needs to happen to make your child get better?: _____

What are your goals and expectations for your visit?:_____

Has your child you lost time from school in the past year due to his/her health concerns?:

□0-2 Days □3-14 days □More than 15 days

Rate your child's health today: ___Poor ___Fair ___Good ___Very Good ___Excellent

Medical History

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

List all any prescription and over the counter medications and supplements 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 imaging including approximate date and for what (X-Rays, MRI, CT Scan, EKG, EEG, endoscopoy etc):

_____

List all past and current medical diagnoses: _____

Has the child ever had a psychiatric diagnosis? (When and what): _____

Has the child ever taken antibiotics?: □Yes □No

If yes, when was the last time he/she have taken antibiotics and for how long?: _____

If yes, how often has he/she taken antibiotics?: □Less than 5 times □More than 5 times

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:_____

Birth of child:

The child was born: ___Naturally ___C-section ___I don't know

The child was born: ___Full term ___Premature _____weeks ___Late term _____weeks

Mother's age at child's birth: _____

Any significant complications during the pregnancy?: _____

Any significant complications during labor and delivery?: _____
Any significant complications during the first few months of life?: _____
Is or was the child breastfed? □Yes □No □I don't know If yes, for how long? _____
If no, what was the source of nutrition?: _____
Birth weight: _____ Birth length: _____ Blood type: _____ □Not Sure?

Developmental History:
When did your child first sit up?: _____
When did your child first begin to crawl?: _____
When did your child begin walking?: _____
When did your child begin talking?: _____
When did your child begin to read?: _____

Diet History:
Onset of food introduction, (when, how and what): _____
Any Foods/food groups avoided?: _____ Why?: _____
Food cravings: _____
Number of meals eaten a day: _____ Number of meals eaten out a week: _____
What has he/she eaten in the last 24 hours?:
Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Dinner: _____
Cups Water/day:_____ Other liquids: _____
Does he/she 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: _____
_____
Does he/she 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: _____
_____
Does he/she have *any* history of food poisoning? If yes, describe approximately when: _____
How often does he/she have a bowel movement?: _____
What is the consistency of the bowl movements?: ___Soft & well formed ___Difficult to pass ___Loose
___Diarrhea ___Alternating Other:_____

Sleep History:
What is the typical time the child goes to bed and wake up?: _____
How would your child rate their sleep?: ___Poor ___Fair ___Good ___Very Good ___Excellent
How long does it take him/her to fall asleep?: _____
Does your child experience frequent dreams or nightmares?: _____
Any night terrors? □Yes □No If yes, how often: _____

What position does he/she sleep in?: _____

Social History:

How would you describe your child's mood?: _____
What triggers changes in their mood?: _____
What are his/her fears?: _____
On a scale from 1-10 how is your child's energy on a typical day? (Circle one answer):
No energy 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Very energetic
What affects their energy the most?: _____
Does your child exercise? Describe: _____
Is your child in school?: □Yes □No School: _____ Grade: _____
Is there any difficulty at school? □Yes □No
If yes, please describe:_____ _____
Any siblings? □Yes □No If yes, please indicate names, sex and ages::_____
_____
Any pets or farm animals at home?: □Yes □No If yes, please describe:_____
Are you spiritual or religious?: □Yes □No Religion:_____
Does your religion have any specific dietary requirements?: _____
In the last 3 years has your child traveled out side of the US?: □Yes □No
If yes, to where and when: _____
What are your child's favorite activities?: _____
Does your child watch TV? □Yes □No How many hours/day?: _____
Has your child or the family recently experienced any major life changing events?: □Yes □No
If yes, please describe including when it occurred: _____
Describe you child's temperament, personality, likes and dislikes, and whatever else you think is important to mention: _____
_____

Environmental History:

Which of the following might the child have been exposed to: ___Pesticides ___Mercury /other metals
___Garden chemicals ___Solvents ___Mold ___Second hand smoke
___Toxic fumes/chemical ___Dry cleaning chemicals ___Aluminum cookware
___Non-stick/Teflon Cookware ___Other _____
Where does your drinking water come from?: □Well □City Water
Is a water filter used in the home?: □Yes □No

Review of Systems: Check all that apply

GENERAL ☐ Anxiety ☐ Chills ☐ Depression ☐ Fatigue ☐ Fever ☐ Headache ☐ Light-headedness ☐ Nervousness ☐ Night Sweats ☐ Weight changes Other:_____	**SKIN** ☐ Acne ☐ Brittle nails ☐ Dandruff ☐ Hives/itching ☐ Eczema ☐ Jaundice ☐ Nail fungus ☐ Psoriasis ☐ Rash ☐ Sores/ulcers Other:_____	**EYE/EAR** ☐ Blurred vision ☐ Double vision ☐ Eye tearing ☐ Eye dryness ☐ Earache ☐ Ear discharge ☐ Ear infection ☐ Hearing loss ☐ Ringing in the ears Other:_____	**NOSE/THROAT** ☐ Bad breath ☐ Bleeding gums ☐ Cold sores ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness ☐ Nosebleeds ☐ Stuffy or runny nose ☐ Teeth or gum problems ☐ Tonsils removed Other:_____
CARDIOVASCULAR ☐ Anemia ☐ Arrhythmia/murmur ☐ Cold hands/fees ☐ Easy bruising ☐ High blood pressure ☐ Low blood pressure ☐ Swelling in hands/feet Other:_____ _	**RESPIRATORY** ☐ Asthma ☐ Pain with breathing ☐ Persistent cough ☐ Pneumonia ☐ Shortness of breath ☐ Wheezing Other:_____ _	**GASTROINTESTINAL** ☐ Abdominal pain ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Excessive thirst/hunger ☐ Foul odor in stool/gas ☐ Gas/Bloating/Belching ☐ Ingestion/heartburn ☐ Nausea/vomiting ☐ Poor appetite Other:_____ _	**GENITO-URINARY** ☐ Bed wetting ☐ Blood in urine ☐ Change in urine odor ☐ Frequent urination ☐ Painful urination Other:_____ _
MUSCULOSKELETAL ☐ Backache ☐ Joint pain ☐ Muscle pain/weakness Other:_____ _	**NEUROLOGIC** ☐ Attention deficit ☐ Dizziness/vertigo ☐ Fainting ☐ Numbness/weakness ☐ Seizures/epilepsy ☐ Speech disorder Other:_____ _	**ENDOCRINE** ☐ Diabetes ☐ Hyperthyroid ☐ Hypothyroid ☐ Low blood sugar Other:_____ _	**MALES ONLY** ☐ Breast tissue changes ☐ Lump in testicles ☐ Penile discharge ☐ Sore penis Other:_____ _
FEMALES ONLY Age of menarche_____ ☐ Breast tissue changes ☐ Menstrual clotting ☐ Mid-cycle bleeding ☐ Nipple discharge ☐ Painful menses ☐ PMS symptoms	☐ Vaginal discharge ☐ Vaginal pain Other:_____ _ Does she use tampons? ☐Y ☐N ***Date of last***: Menstrual period _____	Current Height: _____ Current Weight: _____	

Family History: Please list if any of the child's family members 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 condition.

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

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 your child is 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/Guardian Signature Date

_____
Print Name

_____
Relationship to Patient

Naturopathic Healing
DR. STEPHANIE SOUSA

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: Live real-time audio/video communication through interactive technology that enables a patient and doctor who are separated by distance to interact simultaneously 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 Dr. Sousa Cardoso.

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. And in-office appointments are required once a year.

Risks and Consequences: 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 office policies.

Naturopathic Healing
DR. STEPHANIE SOUSA

Authorization and Consent to Participate in Telemedicine Consultation

FOR CONNECTICUT RESIDENTS

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

FOR OUT OF STATE RESIDENTS

I _____, am aware telemedicine is not a service that is available to me.

_____ _____
Patient/Guardian Signature Date

_____
Relationship to Patient

Naturopathic Healing
DR. STEPHANIE SOUSA

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: _____

Naturopathic Healing
DR. STEPHANIE SOUSA

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

Authorization to Release Medical Information to Family Members/Friends

Privacy rules set limits on what we ae allowed to discuss about you with family, friends and other people who are involved in your care. This form allows you to tell us who we may talk with about your medical care. This includes appointment and scheduling information, lab and test results, treatment and billing information. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

1. _____ Relation to patient:_____
2. _____ Relation to patient:_____
3. _____ Relation to patient:_____

_____ _____
Patient/Guardian Signature Date

_____
Relationship to Patient

Naturopathic Healing
DR. STEPHANIE SOUSA

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 Aetna, 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 & **Medicaid (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

First Office Visit Establishing Care (60-74 mins)	225
First Office Visit Establishing Care (45-59 mins)	195
First Office Visit Establishing Care (30-44 mins)	165
First Office Visit Establishing Care (15-29 mins)	135
Return Office Visit Continuing Care (40-54 mins)	165
Return Office Visit Continuing Care (30-39 mins)	125
Return Office Visit Continuing Care (20-29 mins)	95
Return Office Visit Continuing Care (10-19 mins)	65
Blood Draw/Finger Prick (15 mins)	25
Constitutional Hydrotherapy (30-45 mins)	75
Contrast Hydrotherapy (15 mins)	25
Combination/special order remedy	12
Single remedy	6

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.