

**We are pleased to welcome you as a new patient!**

Mission: To provide you with comprehensive and compassionate natural health care.

How: Dr. Sousa Cardoso will develop a personalized treatment plan for you which may include lab tests, a physical exam, nutritional supplements, botanical medicines, or diet and lifestyle changes.

At the end of your appointment Dr. Sousa Cardoso will ask to see you again for a follow up about 2-6 weeks later.

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.

**Things to bring with you:**

- Filled out paper work
- Medications
- Supplements
- Any labs/imaging other tests from the last 12 months

If you need to cancel or reschedule your appointment, please call our office 24 hours in advance at 203.431.1688.

Dr. Sousa Cardoso looks forward to meeting with you!



**Pediatric General Information:**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Parent 1:** Mother Father Other Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

In the event you do not answer your contact phone number, Dr. Sousa Cardoso ☐MAY ☐MAY NOT leave a voicemail message.

**Parent 2:** Mother Father Other Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

In the event you do not answer your contact phone number, Dr. Sousa Cardoso MAY MAY NOT leave a voicemail 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 Cardoso?: \_\_\_\_\_

**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 Cardoso 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.

\_\_\_\_\_  
Patient/Guardian Signature

**Reason for the visit:** \_\_\_\_\_

When did this condition/symptom start?: \_\_\_\_\_

What expectations do you have for your visit today?: \_\_\_\_\_

When was the last time your child felt really well?: \_\_\_\_\_

**Medical History:**

**Pediatrician:** : \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

**List all prescription and over the counter medications and supplements your child takes and their dose:**

_____	_____
_____	_____
_____	_____
_____	_____

**List all allergies to the following and describe the reaction:**

Medications: \_\_\_\_\_

Foods: \_\_\_\_\_

Environmental: \_\_\_\_\_



List any hospitalizations with approximate dates and reason: \_\_\_\_\_

List any surgeries with approximate 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 experienced: \_\_\_\_\_

List all past and current medical diagnoses: \_\_\_\_\_

Has your child ever had a psychiatric diagnosis? (When and what): \_\_\_\_\_

Has your child ever taken antibiotics?: Yes No

If yes, when was the last time he/she took antibiotics and for how long?: \_\_\_\_\_

Childhood illness (Check off any that your child 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 your child has 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 your child have any adverse effects or reactions from any immunizations?: Yes No I don't know

If yes, please explain: \_\_\_\_\_

#### Your child's birth:

Child was born: ☐ Naturally ☐ C-section ☐ I don't know

Term: ☐ Full term ☐ Premature ☐ Late term ☐ I don't know

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: \_\_\_\_\_

#### 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): \_\_\_\_\_

Foods avoided: \_\_\_\_\_ Why?: \_\_\_\_\_

Food cravings: \_\_\_\_\_

Number of meals eaten a day: \_\_\_\_\_ Number of meals eaten out a week: \_\_\_\_\_

### What has your child eaten in the last 24 hours?:

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

Cups Water/day: \_\_\_\_\_ Milk/day: \_\_\_\_\_ Juice/day: \_\_\_\_\_ Soda/Other liquids/day: \_\_\_\_\_

Does your child 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 your bowel movement? ☐ Soft & well formed ☐ Difficult to pass ☐ Loose

☐ Diarrhea ☐ Alternating Other: \_\_\_\_\_

### Sleep History:

What is the typical time your child goes to bed and wakes up?: \_\_\_\_\_

How would you rate his or her sleep?: ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

How long does it take your child to fall asleep?: \_\_\_\_\_

Any night terrors or nightmares?: \_\_\_\_\_

What position does your child sleep in?: \_\_\_\_\_

### Social History

How would you describe your child's mood?: \_\_\_\_\_

What triggers changes in your child's mood?: \_\_\_\_\_

What are his or her fears?: \_\_\_\_\_

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

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

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:: \_\_\_\_\_

Do you have 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 have you traveled outside of the US?: Yes No

If yes, to where and when: \_\_\_\_\_

What does your child enjoy doing most?: \_\_\_\_\_

Does your child watch TV? Yes No If yes, how many hours used per day?: \_\_\_\_\_

Does your child own a tablet or a phone? Yes No If yes, how many hours use per day?: \_\_\_\_\_

Describe your child's temperament, personality, likes and dislikes, and whatever else you think is important to mention:

### Environmental

Which of the following might have your child been exposed to: \_\_\_Non-stick/Teflon Cookware \_\_\_Pesticides

\_\_\_Mercury /other metals \_\_\_Garden chemicals \_\_\_Aluminum cookware \_\_\_Mold

\_\_\_Toxic fumes/chemicals \_\_\_Second hand smoke \_\_\_Dry cleaning chemicals \_\_\_Solvents

\_\_\_Well \_\_\_City Water \_\_\_Bottled Water \_\_\_Other \_\_\_\_\_

Is there a water filter in the home?: 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: Circle all that apply to you *current***

**GENERAL**

Chills  
Fatigue  
Fever  
Lightheadedness  
Loss of sleep

**HEAD/NECK**

Hair loss  
Headaches  
Head Injury  
Pain or stiffness in neck  
Poor concentration  
TMJ problems/jaw clicks  
Swollen glands

**EYE**

Changed vision  
Eye tearing  
Eye dryness  
Glaucoma  
Glasses/contacts

**EAR/NOSE**

Earache  
Ear discharge  
Excessive earwax  
Ear infection  
Hay fever/allergies  
Nosebleeds  
Ringing in the ears  
Stuffy or runny nose

**MOUTH/THROAT**

Bad breath  
Bleeding gums  
Cold sores  
Difficulty swallowing

Dry mouth  
Fillings  
Hoarseness

**CARDIOVASCULAR**

Anemia  
Arrhythmia/murmur  
Blood clots  
Chest pain  
Cold hands/feet  
Deep leg pain  
Easy bruising  
Palpitations  
High cholesterol  
High/low blood pressure

**RESPIRATORY**

Asthma  
Bronchitis  
Coughing up blood  
Pain with breathing  
Persistent cough  
Pneumonia  
Shortness of breath  
Sputum  
Wheezing

**GASTROINTESTINAL**

Abdominal pain  
Blood in stool  
Change in appetite  
Constipation  
Diarrhea  
Eating disorder  
Foul odor in stool/gas  
Gas/Bloating/Belching  
Ingestion/heartburn  
Nausea/vomiting

**GENITO-URINARY**

Blood in urine  
Change in urine odor  
Decreased stream  
Frequent urination  
Frequent UTI  
Incontinence  
Kidney Stones  
Painful urination

**ENDOCRINE**

Excessive Thirst  
Excessive Hunger  
Hypothyroid  
Hyperthyroid  
Low blood sugar

**NEUROLOGIC**

Anxiety  
Depression  
Dizziness/vertigo  
Fainting  
Nervousness  
Loss of balance  
Loss of coordination  
Seizures/epilepsy  
Suicidal thoughts

**MUSCULOSKELETAL**

Joint pain  
Joint stiffness  
Joint swelling  
Muscle pain/weakness  
Paralysis/weakness

**SKIN**

Acne

Brittle nails  
Dandruff  
Eczema  
Hives  
Nail fungus  
Psoriasis  
Rash  
Sores/ulcers

**MALE CONDITIONS**

Breast lumps  
Lump in testicles  
Pain with intercourse  
Penile discharge  
Sore penis

**FEMALE CONDITIONS**

Breast changes/pain  
Heavy or excessive flow  
Lack of menses  
Mid-cycle bleeding  
Menstrual clotting  
Nipple discharge  
Painful menses  
Vaginal discharge  
Yeast infection  
Age of menarche:  
Duration of bleed:  
Are cycles regular? Y N  
Length of cycle:  
Are you pregnant?: Y N  
Total# of pregnancies:  
Any hormones or birth control pills?: Y N  
Tampon Use? Y N  
*Dates of last:* Menstrual period \_\_\_\_\_

**Thank you for taking your time filling this out!**

*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



### Informed Consent for Treatment

I, \_\_\_\_\_, consent to be treated by Dr. Sousa Cardoso.

I will inform Dr. Sousa Cardoso of any disease I may have, any prescription or over the counter medications I am taking and if I am pregnant, or suspect to be pregnant or am breastfeeding. Initials \_\_\_\_\_

I understand Dr. Sousa Cardoso will answer my questions to the best of her ability and results are not guaranteed. I do not expect Dr. Sousa Cardoso to be able to anticipate and explain all risks and complications. Initials \_\_\_\_\_

Services received at Dr. Sousa Cardoso'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 Cardoso does not recommend abruptly stopping or tapering down of prescriptive medications without the supervision of the prescribing medical doctor as this can cause serious consequences. Initials \_\_\_\_\_

I understand that the treatments provided or recommended by Dr. Sousa Cardoso 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 Cardoso 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	_____ Relationship to Patient	_____ Date
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### Authorization to Release Medical Information to Family Members/Friends

Privacy rules set limits on what we are 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	_____ Relationship to Patient	_____ Date
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## Authorization and Consent to Participate in Telemedicine Consultation

**Purpose and Benefits:** 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.

- Some states or insurance plans place restrictions on where the patient can receive virtual care.
- Residence within Connecticut is required for telemedicine consultations with Dr. Sousa Cardoso. Residence/location will be verified prior to scheduling appointments.
- This service is only available to established patients; first office visits must be in-office (face- to –face).
- 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 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 Cardoso 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. All existing confidentiality protections under federal Connecticut state law apply to information disclosed during the telemedicine consultation (HIPAA). 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 withdraw your consent to telemedicine consultations at any time without affecting your right of future care or treatment. You have the option to consult with Dr. Sousa Cardoso in at her office.

**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 Cardoso 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 as well as 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 at in office rates. Please see office policies.

### 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.*

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

### FOR OUT OF STATE RESIDENTS

*I \_\_\_\_\_, am aware telemedicine is not a service that is available to me.*

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
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 Cardoso 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. 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 Cardoso and that any action taken by Dr. Sousa Cardoso, 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

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

### Credit Card Consent Form

I, \_\_\_\_\_, give Naturopathic Healing LLC permission to charge my credit card (specified below) for services rendered, late appointment fees, cancellations 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) and includes charges for services rendered to:

☐ Myself ☐ Other \_\_\_\_\_

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, I am 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.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



### 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. Telemedicine consultations are billed the same as in office appointments. Effective May 1, 2021: New patients who have rescheduled their new patient visit more than two (2) times will be required to leave a non-refundable deposit in the amount of \$50. This deposit will be collected via credit card over the phone or via a Square invoice.

**In Network Insurance:** Dr. Sousa Cardoso currently participates with Aetna, Anthem BCBS, Cigna, Connecticare, First Health Network, Oxford. **It is the patient's responsibility to ensure coverage and naturopathic medicine is covered by their plan.** 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 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.

**Medicare:** Medicare (and Medicare Advantage plans) **DOES NOT** recognize naturopathic medicine and 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 Cardoso will provide the patient with all necessary codes.

**Out of Network Insurance/No Insurance:** If we do not participate with your insurance company, or you are not insured, you will be considered a self-pay patient and you will be responsible for payment in full at the time of service. You can ask for a Good Faith Estimate.

#### Payment Fee Schedule for Self-Pay Patients 2026

First Office Visit Establishing Care (60-74 mins)	225	Forms (each)	25
First Office Visit Establishing Care (45-59 mins)	195	Blood Draw/Finger Prick (15 mins)	25
First Office Visit Establishing Care (30-44 mins)	165	Constitutional Hydrotherapy (30-45 mins)	75
First Office Visit Establishing Care (15-29 mins)	135	Contrast Hydrotherapy (15 mins)	25
Return Office Visit Continuing Care (40-54 mins)	165	Combination/special order remedy	15
Return Office Visit Continuing Care (30-39 mins)	125	Nasosympatico	15
Return Office Visit Continuing Care (20-29 mins)	95	Single remedy	7
Return Office Visit Continuing Care (10-19 mins)	65		

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

**Missed Appointment/ Cancellation Policy:** I am aware that I will be charged a **25\$** late cancellation fee for cancellations with less than 24 hours' notice. And I will be charged **50\$** for missing an appointment. 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.*

**Email Policy:** Email is 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 Cardoso 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 Cardoso will respond to emails within 24-48 hours, Monday through Friday only. If you have emailed Dr. Sousa Cardoso 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 Cardoso 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 Cardoso you acknowledge that you are comfortable with having an email relationship with Dr. Sousa Cardoso knowing that Dr. Sousa Cardoso'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 Cardoso. 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 Cardoso to contact you via a specific way: email, cell phone, mail.
- Ask Dr. Sousa Cardoso 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 Cardoso 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/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

You have a choice to:

- Allow Dr. Sousa Cardoso to share information with your family, close friends, and other's involved in your care.
- Allow Dr. Sousa Cardoso to share your health information in a disaster relief situation
- Allow Dr. Sousa Cardoso to include your information in a hospital directory.
- *If you are unable to tell Dr. Sousa Cardoso 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 Cardoso 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 Cardoso 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 Cardoso 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.