

Office of Dr. Christina Youngren
Licensed Naturopathic Doctor

WELCOME TO THE NATUROPATHIC MEDICAL PRACTICE OF DR. CHRISTINA YOUNGREN!

Thank you for choosing the medical office Dr. Christina Youngren, N.D., and entrusting me with your healthcare. The following information regarding the office will help familiarize you with my practice and prepare you for your upcoming appointment. Please review the following information carefully, and if you have questions, do not hesitate to call.

My practice is dedicated to providing individualized medical care using a preventive medical approach, which entails educating and empowering my patients about their full health picture. I am nationally board certified by The North American Board of Naturopathic Examiners, as a licensed naturopathic doctor in the state of California and Arizona.

The office is located at 2772 Bush Street just a few blocks from Kaiser Permanente, Mt Zion Hospital – UCSF, and The Osher Center. My hours of operation are Monday, Wednesday and Friday from 9am to 6pm, expect for major Holidays. For your convenience, a new patient packet, which includes office policies and most importantly, the Health Questionnaire. The paperwork is to be completed and signed prior to your upcoming appointment. **You can mail your paperwork back to the office or arrive 15 minutes early so that I may review the Health Questionnaire prior to your visit.** Also keep in mind, your initial visit is approximately one and a half hours and also includes a follow up appointment, to be scheduled within 7 to 10 days of the initial visit.

Currently my practice is not a recognized provider for any insurance companies nor do I submit claims to insurance companies on your behalf. However, I will provide you with the information necessary for you to submit your claim to your insurance company. This does not ensure any coverage from your insurance company and I advise you to contact them directly to have a full understanding of these benefits prior to your visit. My office requires payment in full at the time services are rendered.

I make every effort to stay on schedule, however, emergencies occur in any medical practice. When they do, I will do my best to keep you informed of the delay, and give the option to reschedule if you would prefer. Patients who arrive late for appointments may be asked to reschedule. **Also, if you must cancel your appointment, please call the office at (415) 742-2655 as soon as possible. There is an initial \$35 charge for cancellations less than 24 hours from your appointment time, thereafter it is the cost of your visit unless it can otherwise be filled.** Advance notice also allows me to offer the available time to the next person my waiting list. Welcome to my practice. Please feel free to provide any feedback and suggestions for my continuing improvement.

I look forward to meeting you.

Sincerely,

Dr. Christina Youngren
Licensed Naturopathic Doctor

General Policies

This document contains important policy information that pertains specifically to you. Please read over the entire document, if you have any questions please feel free to ask the doctor.

Appointments

We consider an appointment to be an agreement between you and the doctor. If for any reason you need to and do not cancel your appointment your doctor becomes unable to provide service to another patient during your scheduled time. We are responsible to be onsite and provide our services, or to inform you otherwise; you are responsible for keeping the appointment or giving us a 24-business hour notice of cancellation. Should you decide not to keep the appointment without giving the appropriate notice, you will be charged a 35.00 cancellation fee the first time. Thereafter it will be the cost of your visit unless your appointment can be filled with another patient. Please note that insurance companies do not reimburse for missed appointments. _____ please initial

Payment

Dr. Youngren requires payment in full at the time services are rendered. Currently we accept Check and Cash. There will be a \$35.00 fee for all returned checks. _____ please initial

Insurance

Dr. Youngren is not a recognized provider for any insurance companies nor does Dr. Youngren submit claims to insurance companies on your behalf. We will however, provide you with the information necessary for you to submit your claim to your insurance company. This does not ensure any coverage or reimbursement from your insurance company. _____ please initial

Emergencies

If you have a true medical emergency or serious medical concern you are to call 911 immediately. If you have an urgent medical concern please call the office; if it is after regular business hours (9am to 6pm) please leave a message for Dr. Youngren at (415) 742-2655 and someone will return you call the next business day, if you feel you can not wait until the next business day it is your responsibility to seek the appropriate medical care. _____
_____ please initial initial

By signing below, I understand and agree to the patient payment and cancellation policy. I guarantee payment of all charges incurred as a patient of Dr Youngren.

Patient Signature or Parent/Guardian (minor)

Date

Printed Name

Informed Consent and Request for Naturopathic Medicine

I understand that the evaluation, diagnosis and treatment by a naturopathic doctor, and specifically by, Dr. Christina Youngren, may include but is not limited to:

- Interview (history taking)
- Physical examination
- Common diagnostic procedures (such as, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (such as the therapeutic use of foods, diet plans, nutritional supplements; intravenous and intramuscular injections under supervision)
- Botanical medicines and nutraceuticals [also referred to as supplements] (such as the prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures-which may contain alcohol, suppositories, topical creams or other forms.)
- Homeopathic remedies (highly diluted substances)
- Over the counter medications
- Prescription medications to be filled at a pharmacy under supervision

I understand and I am informed that in the practice of Naturopathic Medicine there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:

- Potential risks: pain, discomfort; allergic reaction to prescribed herbs, supplements, prescription medications; an aggravation of pre-existing symptoms especially with heavy metal detoxification.
- Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I (print name), _____ acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Signature

Date

Confidential Patient Information

Patient Contact Information

Name: _____ / _____ / _____
(Last) (First) (Sex) (Date of birth)
Permanent Address: _____ City: _____ State: _____ Zip: _____
Temporary Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____
Email Address: _____

Name of nearest relative not living with you: _____ Relation: _____
Phone: (____) _____

Additional Patient Information

Today's Date: _____ / _____ / _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)
Whom may we contact in case of an emergency: _____ Relationship to you: _____
Emergency Contact #: (____) _____

How did you first hear of us?

- From a Patient Your Business Website Office Sign The Radio/TV/Theater
 The Newspaper The Internet, please specify _____

How did you find our location or phone number? _____

Do you have a M.D. primary care or Internist that you also see? Yes No

Name: _____

Were you referred by another physician: Yes No

If "Yes", could you provide us with as much information as possible for the Referring Physician?

Referring Physician's Name: _____

Address, City, State, Zip: _____

Telephone Number: _____

*I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned doctor to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered on me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Furthermore, in the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time the account is placed with the agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection. Releases may be requested prior to specific procedures being performed (i.e., minor surgery, etc.) **Clinic Policy requires payment at time of services.***

Patient's Signature Parent or Guardian's Signature

Date

Notice of Privacy Practices

To the patient. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The commitment to your privacy

This practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that this practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing Dr. Christina Youngren at 2772 Bush Street, San Francisco, CA 94115. Note: *We must respond to this request within 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for the practice. To request an amendment, your request must be made in writing and submitted to 2772 Bush Street, San Francisco, CA 94115. You must provide us with a reason that supports your request for amendment.
Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the office.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Dr. Christina Youngren directly. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

You will be asked to sign acknowledging receipt of the HIPAA Privacy Practices at your first visit. If you have any questions regarding this notice or our health information privacy policies, please notify Dr. Youngren.