The Rocking Chair LLC

60 Grand Avenue Englewood, NJ. 07631
www.therockingchair.org

NATUROPATHIC CLIENT INFORMATION SHEET

Client's Last Name:_____ First:_____ Middle Initial_____

Mailing Address_____ City/State/Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

Birthdate_____ Soc.Sec.Number_____-_____-_____ Male_____ Female_____

E-mail_____ Marital Status: M S D W Employed by:_____

Employer's Address_____ City/State/Zip_____

Referred by_____

IF CLIENT IS A CHILD OR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

Responsible Party's Name:_____ Relation To Client_____

Mailing Address_____ City/State/Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

Birthdate_____ Soc.Sec.Number_____-_____-_____ Male_____ Female_____

E-mail_____ Marital Status: M S D W Employed by:_____

Employer's Address_____ City/State/Zip_____

EMERGENCY CONTACT (Someone who does not live with you):

Name_____ Relationship_____

Address_____ City/State/Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account and any professional services rendered. Having completed the above, I certify that this information is true and correct to the best of my knowledge. I will notify The Rocking Chair LLC. of any changes in the above Information

Signature _____

Date:_____

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Welcome to The Rocking Chair LLC, serving women throughout their reproductive life span. Our goal is to provide you timely, respectful, quality care in a pleasant practice environment.

Appointments and cancellations
Clients are seen in the office by appointment only. For your convenience we attempt to adhere to our schedule as closely as possible. Notice of cancellation is requested 24 hours in advance to enable us to give your appointment to another client. If you cannot or do not plan to keep your appointment please let us know 24 working hours in advance to avoid a charge.

Emergencies
If you have an immediate life and death emergency, call 911 or go promptly to your nearest emergency room for assistance.

During office hours, The Rocking Chair LLC will return calls as quickly as possible. We make a strong effort to return all client calls on the day received. Please make sure that we have a current home, cell and work phone number. If you feel that your concern is urgent please make it clear when leaving a message so that we do not underestimate your concern.

Office Charges
Payment for all office charges is required at the time of the visit. We are happy to supply you with the necessary forms which you may submit to your insurance company for reimbursement. There is a charge for appointments missed, cancelled or changed with less than 24 working hours of notice. Please remember, this is fully your time. Unlike most doctors' offices, we do not over-book or double book appointments. Please notify us promptly if you cannot make your appointment so that we can offer the time to someone else.

Signature:_____ Date:_____

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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.

If you have any questions about this notice please contact our office privacy officer.

Who Will Follow This Notice:

- Any physician or other healthcare professional authorized to enter information into your medical record
- All employees, staff and office personnel
- Healthcare professionals outside this office involved in your care and treatment for the purpose of providing health care services to you
- All these persons follow the terms of this notice. These persons may share medical information with each other for treatment, payment or purposes as described in this notice.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by office personnel or a healthcare professional. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We Are Required By Law To:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you
- Follow the terms of this notice.

HowWe May Use and Disclose Medical Information About You:

The following categories describe different ways that we use and disclose medical information. The ways we are permitted to use and disclose information will fall within one of these categories and may require written consent from the client, parent or legal guardian if the client is a legal minor.

I. Treatment Within The Rocking Chair LLC:

We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to our staff, doctors, nurses or other office personnel who are involved in taking care of you at The Rocking Chair LLC.

II. Insurance (Payment and Provider Audits):

We may disclose medical information to coordinate and manage health care with a third party-insurance company/managed care. We may use and disclose health information about you, upon a written request, so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an

insurance company, or a third party (e.g. managed care). For example, we may need to give your health plan information about treatment you received so that your health plan will pay us or reimburse you for treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may be required to submit your medical record to your insurance company for review of services provided to you by our agency. Release of this information is secured from you at the time of your initial visit to The Rocking Chair LLC. The insurance company is also required to adhere to the same confidentiality standards set forth by HIPAA (Health Insurance Portability and Accountability Act of 1996).

III. Healthcare Operations:

We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff caring for you. We may also disclose non-identifying information to doctors, nurses, healthcare professionals and personnel for review and learning purposes. We will remove identifying information so others may use it to study healthcare and healthcare deliveries without learning the identities of specific clients. We may use and disclose your medical information with a third party "business associate" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we have a written contract that will protect the privacy of your health information.

IV. Individuals Involved In Your Care Or Payment For Your Care:

We may release medical information about you to a friend or family member who is involved in you medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for your care, upon written consent.

V. By Court Order:

We will disclose medical information about you when required to do so by court order.

VI. Serious Health Safeties and Emergencies:

We may use and disclose medical information in an emergency treatment situation. If this happens, your healthcare provider shall try to obtain your consent as soon as reasonably practicable after delivery of treatment.

VII. Evidence of Abuse and Neglect:

We may disclose medical information about you to notify the appropriate government authority if we suspect child abuse, neglect of a child or elderly person or domestic violence.

VIII. Disclosure of Intent to Harm Self or Others:

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety of the health and safety of the public or another person. However, any disclosure would only be to someone able to help prevent the threat.

IX. Workers' Compensation

We may release medical information, upon written consent, about you for your workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

X. Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a valid court administrative order. In the event that we need to disclose medical information about you in response to a

subpoena, discovery request, or other lawful process be to someone else involved in the dispute, we will need to obtain your written consent to do so.

XI. Food and Drug Administration:

We may release medical information to a person or company required by the food and drug administration to report adverse advents, product defects or problems, track products; to enable product recalls, without using information to identify you.

XII. Military Activity and National Security:

If you are a member of the armed forces we may release medical information about you, upon written request, as required by military command authorities. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities.

XIII. Primary Care Physician:

We may use and disclose health information about you to correspond with your primary care physician when required by our insurance company/managed care company, upon written consent.

Your Rights Regarding Medical Information About You:

You have the following rights regarding medical information we maintain about you:

I. Right to Inspect and Copy:

You have the right to inspect and obtain a copy of your health information and/or summary of your medical information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit a request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. We require 30 to 60 days to respond after receiving the written request. If we need additional time to respond, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we deny part or all of your request, we will provide written denial that explains our reasons for doing so. If we have reason to deny only part of your request, we will provide complete access to a copy of the remaining parts after excluding the information we cannot let you inspect or copy.

II. Right to Amend:

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the office. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or it does not include a reason to support the request.

III. Right to An Accounting of Disclosures:

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment or payment. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. However, if such limitations of accounting and disclosures make it impossible for us to either provide appropriate care and/or collect payment from a payer, we have the right to discontinue services. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You must make your request in writing.

IV. Right to Confidential Communications:

You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. We must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the basis of your request. Contact the office Privacy Officer if you require such confidential communications.

V. Right to Paper Copy of this Notice:

You have the right to a paper copy of this notice.

VI. Changes to This Notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office.

VII. Complaints:

If you believe your rights have been violated, you may file a complaint with the office Privacy Officer or with the Secretary of the Department of Health and Human Services. ***You will not be penalized for filing a complaint.***

I have read the above notice of Privacy Practices and understand my rights.

Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy to the *Notice of Privacy Practices.*

Print Client Name:_____

Client Signature:_____

Parent/Guardian Name:_____
(if applicable)

Date:_____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices,* but acknowledgement could not be obtained because:

Date: **Initials:** **Reason:**

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CLIENT AUTHORIZATION FORM

I hereby authorize _____ to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

_____

_____

Person or entity requesting the information (your name):

_____

Recipient of the information:

The Rocking Chair LLC_____

This information is being requested for the following purpose(s):

_____

_____

This authorization shall remain in effect from the date signed below until (expiration date or event):

_____

I understand that:

- I may inspect or copy the protected health information to be used or discussed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me proving this authorization (except to the extent that the authorization is for research – related treatment, in which case you may refuse to provide that research – related treatment.)

Client Name_____ Signature_____ Date_____

Relationship to Client (if signed by representative)_____

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS INFORMATION

I,_____authorize the following:

The Rocking Chair LLC

TO DISCLOSE THE FOLLOWING INFORMATION:

To _____at the

following address:_____in order

to coordinate treatment.

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. If not previously revoked, this consent will terminate one year from the date written below.

_____ _____
Signature of Client/Parent/Authorized Representative Date

I DO NOT WISH TO AUTHORIZE RELEASE OF INFORMATION

_____ _____
Signature Date

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Informed Consent Form

I, _____ (please print your name clearly), herby certify by my signature at the bottom of this page that:

I have been informed that although Marda Sussman is a Doctor of Naturopathic Medicine, the State of New Jersey does not recognize naturopathic physicians as licensed medical doctors. I understand that Dr. Sussman is not licensed to diagnose or treat specific diseases, nor prescribe drugs or perform surgery. I recognize that any assessment made by Dr. Sussman will be performed for the purpose of maximizing health and body function and not for the purpose of diagnosis. I understand that any herbs, nutritional supplements, and homeopathic remedies recommended to me by Dr. Sussman are neither a treatment for my condition nor a replacement for medication.

I understand that Dr. Sussman advises me to seek care from a licensed physician for any symptoms, complaints, or conditions that I feel require such care. I recognize that the services of Dr. Sussman are provided for the purpose of optimizing my health. I have been informed that it is my responsibility to report all changes in my health, medications, and self-medications (including natural and over-the-counter substances) to Dr. Sussman while seeking her services.

Accordingly, I sign this informed consent to express that I have voluntarily sought naturopathic counseling from Dr. Sussman and I herby release each of The Rocking Chair LLC and The Natural Path LLC and each of their members, principals, shareholders, officers, directors, agents, trainers, employees and successors and any and all related companies of each of the foregoing, whether known or unknown to me and Dr. Sussman (all of the foregoing, collectively, the "**Released Parties**") from any liability and agree not to bring a lawsuit of any kind against the Released Parties.

I intend this consent form to cover the entire course of my naturopathic counseling. I understand that I am free to discontinue participation in these procedures at any time.

I have read this consent form and have fully understood its contents.

Client signature: _____

Date: _____