



Dear Patient,

Welcome! Thank you for choosing us for your family health care needs. We are here to serve your medical needs, help educate you about natural therapies and ways to optimize your overall health, and to answer your health care questions.

Enclosed in this packet are several forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time together more effectively. **Please bring these forms to your first appointment.** Your first visit will be a thorough assessment of your health and you should allow an hour for this visit.

If you are unable to keep your scheduled appointment, please let us know at least 24 hours prior to the scheduled time so that we may allow other patients to be seen during that time. We will be glad to reschedule your visit if it becomes necessary to do so.

**Please remember to bring in copies of any recent lab work or medical records and a complete list of medications and dosages you are currently taking.**

I look forward to seeing you. My goal is to become a trusted partner in assisting you with your health care needs.

Yours in health,

Annamarie Pamphilis, ND, RDH

**Annamarie Pamphilis, ND**

PHONE: 440.539.0392

31015 Center Ridge Road, Suite 4, Westlake, OH 44145

[www.MyNsp.com/drannamariepamphilis](http://www.MyNsp.com/drannamariepamphilis) | [www.HealthandBalanceInstitute.com](http://www.HealthandBalanceInstitute.com)

## Consent for Treatment & Financial Policy Statement

Thank you for choosing Dr. Pamphilis for your healthcare needs. We are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

### **Treatment:**

Treatment requires an agreement between you, the patient, and Dr. Annamarie Pamphilis, ND. Any therapy will proceed only with mutual consent. It is possible that certain adverse effects may result from treatments. These could include, but are not limited to, local skin irritation, bruising, temporary pain or discomfort, adverse reactions to prescribed herbs or supplements such as allergic reaction, headache, nausea; and the possible temporary aggravation of symptoms existing prior to treatment.

Because of the possibility of drug interaction with herbal formulas, we require our clients to inform the practitioner of any medications they may be taking, including any dietary supplements and herbs.

**Notice to Pregnant Women:** All female clients must alert the doctor if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

### **Emergency Care:**

We do not administer emergency medical care. In the case of an emergency, please see your medical or osteopathic doctor, the emergency room, or the nearest hospital. After emergency care has been administered, patients often respond well to naturopathic care to accelerate the healing process.

**Payment: Naturopathic Doctors are currently unable to bill insurance in the state of Ohio.** We are a fee for service company and payment is expected at the time of service. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

We accept cash or personal checks as payment. Returned checks are subject to \$25 return fee and no further personal checks will be accepted.

**Phone Calls:** Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. We would prefer that people call with questions rather than leave them unanswered. There is no charge for any call to clarify instructions given at a previous visit.

Phone support is not intended to take the place of an office visit. Phone consultations that cover new material, require new information, take an extensive amount of time, or require a change in treatment plan are considered substitutes for an office visit. These will be billed at the same rate as the visit for which they substitute.

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**Cancellation Policy:**

We all have circumstance come up occasionally that make it difficult to keep appointments. With that in mind, we are happy to accept cancellations or postponements 24 hours in advance. There is no charge if an appointment is cancelled with 24 hours notice. A cancellation with less than 24 hours notice does not allow enough time for other interested clients to be scheduled and is an inconvenience.

**This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. There is a \$50 charge for new patient cancellations and a \$25 charge for follow-up appointment cancellations that are made with less than 24 hours notice.**

- I agree to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding my healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the doctor and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the doctor.

Patient's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

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