ROCKY MOUNTAIN NATURAL MEDICINE, Inc.
CONFIDENTIAL INTAKE FORM

Name ____ Date: ____________
(please print clearly)

Address: ____

City: ______________________ State: _____________ Zip: _____________

Email Address: ____
* *We promise not to sell, trade or otherwise disclose your email to anyone.*

Phone: ___________________ ________ Cell: _____ ____________________
(please include area code)

I give Rocky Mountain Natural Medicine my permission to leave phone messages regarding my appointments. Yes _____ No _____

Birth date: ____________

How did you hear about us? ____

____
(please be as specific as possible, we like to track our advertising efforts and especially like to Thank people for their referrals through our referral rewards program!)

Thank you and we look forward to helping you get healthier!

ROCKY MOUNTAIN NATURAL MEDICINE, Inc.
Alternative therapies disclosure and informed consent to treat for patients

This document is a binding agreement (the "Agreement") between ROCKY MOUNTAIN NATURAL MEDICINE Inc. ("We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the heath care services provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

1. **Consent For Treatment.** You hereby consent to and authorize Dr. Barker to provide You with heath care treatment that involves natural health and wellness consulting. You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk. You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. (Initials) _________

2. **Services.** I understand that Dr. Barker is not providing primary care health services. I understand that Dr. Barker conducted his pre-medical studies at Colorado State University and received his Doctorate in Naturopathic Medicine from Southwest College in Tempe, AZ. I understand that Dr. Barker is licensed as a Naturopathic Physician in the state of OR with prescriptive and primary care privileges, and no licensing board exists in CO. Therefore, Dr. Barker is practicing as a natural health and wellness consultant only. (Initials)_______

3. **Risks.** I understand that no warranty or guarantee has been made to me as to result of care. I realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary procedure(s) planned for me. I have been given an opportunity to ask questions about my condition, conventional treatment, integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of nontreatment, procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. (Initials)_____

4. **Information You Provide Us.** You have provided Us with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided Us with a complete list of all know allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete and up-to-date to the best of Your knowledge. (Initials) _________

5. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. (Initials)_________

BY SIGNING THIS AGREEMENT, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, YOU HAVE RECEIVED A COPY OF THIS AGREEMENT, AND THAT YOU ARE THE PATIENT, GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

Patient/Proxy/Legal Guardian/ Relative

_____________________________ ______________________________ ____________________
Signature Print Name if not the patient Date

DOCTOR'S CERTIFICATION

I hereby certify that one of my associates or I have explained to the patient, or person authorized to consent for the patient, the nature of proposed operation, procedure or treatment. In addition to advising of medically significant alternative modes of treatment, if any, including no treatment, I have explained in lay person terms, the purpose, the potential benefits, the likelihood of success, reasonably foreseeable risks, complications and consequences, including probable duration of procedure-related incapacitation and potential problems related to recuperation and / or anesthesia, if applicable. The patient, or person authorized to consent for the patient has indicated his or her understanding, has consented to the operation, procedure or treatment and to the administration of anesthesia, has had opportunity to ask questions and has stated that no further explanation was desired.

_____________ ____
Date Doctor

ROCKY MOUNTAIN NATURAL MEDICINE, Inc

FINANCIAL POLICY

Thank you for choosing Dr. Jason Barker at Rocky Mountain Natural Medicine for your Naturopathic health care. We are committed to giving you the best care possible, and we want you to completely understand our financial policies. The following is a statement of our Financial Policy, which we need you to read and sign prior to any treatment.

- Payment is due at time of service unless arrangement have been made in advance. Your financial responsibility to us will be your cash fee. We accept cash, check and credit cards (Visa, MasterCard).

- Your insurance plan will most likely not cover the services of Dr. Barker. In the State of Colorado, Naturopathic health care is not yet covered by any insurance plans. However, you may submit your own claim to your insurance company; in rare events some portions of service may be reimbursable to you. Additionally, nutritional supplements prescribed by Dr. Barker may be eligible under your Health Savings Account. Ultimately it is your responsibility to understand what your insurance plan will and will not cover.

- Because Dr. Barker's services are not covered by insurance, you are responsible for the complete charge. Payment is due upon the receipt from our office.

- The following are some, but not all of the costs of Dr. Barker's services, depending on complexity of the case:
  - -New Patient: $120-$155
  - -Return visit: $30-$60
  - -New Patient, Child: $75
  - -Return Child: $45

  Laboratory services:
  -Saliva hormone tests are $50 per hormone tested.
  -Food allergy tests are $200
  -Standard laboratory blood work: Depending on your own insurance plan

I have read and understand ROCKY MOUNTAIN NATURAL MEDICINE Inc.'s FINANCIAL POLICY AGREEMENT, and I agree to be bound by its terms.

__________________________________ ____________________
Name of Patient (PLEASE PRINT) Date

____
Signature of Patient (or Responsible Party if Minor)

ROCKY MOUNTAIN NATURAL MEDICINE, Inc.

CANCELLATION & MISSED APPOINTMENT POLICY

In order to better serve you, please let us know 24 hours ahead of your appointment if you are unable to make it. This lets us provide other patients awaiting an appointment the opportunity to receive care.

If you miss an appointment without providing at least a 24-hour notice you may be responsible for a $75 missed appointment charge.

I, ____________________________________ agree to pay the missed appointment fee if I fail to notify Rocky Mountain Natural Medicine at least 24 hours in advance of my scheduled appointment.

____________________________________ ______________

Signature of Patient (Or Responsible Party if a minor) Date

NOTICE OF PRIVACY POLICIES

ROCKY MOUNTAIN NATURAL MEDICINE, Inc.

We are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. We are required by law to maintain the confidentiality of your individually identifiable health information. We are also required by the Health Insurance Portability and Accountability Act (HIPPA) to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your Protected health Information (PHI)

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our office in a visible location at all times. You will be given the opportunity to review and/or receive a copy of the Privacy Practices of Rocky Mountain Natural Medicine upon request.

By signing this form below, I acknowledge the above terms of the Privacy Policies

____________________________________ _____________________

Patient Signature Date

____

Printed Name

____________________________________ _____________________

Signature of Responsible Party (if a minor) Date