



I N F O R M E D C O N S E N T F O R M

Health Information Privacy and Contact Permission

I acknowledge receipt of the Notice of Privacy Practices for the Integrative Family Medicine, LLC Medical Office (“Your Health Information Rights”) and that I may obtain a paper copy of this Notice of Privacy Practices upon request.

I hereby give my consent for Integrative Family Medicine, LLC to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and Health Care Operations (HCO) including releasing records to insurances. (Integrative Family Medicine, LLC’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have reviewed the Notice of Privacy Practices prior to signing this consent. Integrative Family Medicine, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Integrative Family Medicine, LLC Privacy Officer at 7750 Montpelier Road, Laurel, MD 20723.

With this consent, Integrative Family Medicine, LLC may call my home or other alternative location and leave a message on voice mail / answering machine or in person in reference to any items that assist the practice in carrying out HCO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, that is not personal medical information.

With this consent, Integrative Family Medicine, LLC may discuss medical and/or confidential matters over email when initiated by me (e.g. If an email asks for advice, mentions a medical condition or prescription, etc).

With this consent, Integrative Family Medicine, LLC may mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminder cards and patient statements as well as any items pertaining to my clinical care, **including laboratory results** among others as long as they are marked Personal and Confidential.

With this consent, Integrative Family Medicine, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminder cards and patient statements as well as any items pertaining to my clinical care, including laboratory results.

I have the right to request that Integrative Family Medicine, LLC restrict how it uses or discloses my Protected Health Information to carry out HCO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Integrative Family Medicine, LLC’s use and disclosure of my protected health Information (PHI) to carry out treatment, payment and health care operations (HCO).

Consent to Care

I consent to medical care and treatment from Integrative Family Medicine, LLC. I understand that I am being offered counseling, and that in the end I am responsible for my own healthcare. I understand that these services are adjunctive and consultative in nature, specialized for integrative and complimentary or alternative therapies, and I have been recommended to have a conventional primary care doctor. I understand it is my responsibility to notify the practice if I am trying to get pregnant or breastfeed, and/or if I have any change in diagnoses, conditions, medications or supplements.

Office Policies

I have reviewed and agree to the stated office policies in Integrative Family Medicine, LLC Office Policies (filename “Intro Packet”). I understand that these policies can change without notice and that updates will be posted on the website and/or through mailings and/or on notices displayed in the office.

Initials _____ Date _____

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Insurance

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand Integrative Family Medicine, LLC is not responsible for submitting any claims for any services to your Insurance Company, including but not limited to laboratory fees and office visit charges. I understand Integrative Family Medicine, LLC does not participate with any HMO, Insurance company or the Medicare Program. I understand it is my responsibility to address any problems or issues directly with my insurance company. I understand reimbursement is not guaranteed. I understand charges are expected to be paid at the time services are rendered.

If I have Medicare, I understand the Jennifer Rabenhorst, MD has “opted out” of Medicare and that I cannot submit or be reimbursed by Medicare for any charges in this office. I take responsibility for determining if any secondary insurance will reimburse me for charges.

Complementary Alternative Medicine

I understand that my physician may inform me of or recommend complimentary therapies. I understand that often these therapies have not been thoroughly studied, and that evidence-based medicine is usually lacking. Thus, I understand when my physician may bring up a complementary modality, it is with the understanding that there are not established mainstream protocols, guidelines, or evidence. I understand that by the nature of this, it is not standard of care. I understand that I am under no obligation to embark on a therapy, and that my physician will answer all my questions to the best of her knowledge.

I further understand that some prescription medicines may be recommended for “off-label” use. I understand that this means the physician is prescribing a drug for an indication other than that which is FDA approved. In other words, usage in this manner may not have been studied.

Agreement to Resolution of Concerns

I agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims for medical malpractice against Integrative Family Medicine, LLC or Dr. Jennifer Rabenhorst, MD. Should I initiate or pursue a medical malpractice claim against Integrative Family Medicine, LLC, I agree to use an expert witness (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialists on the same or similar specialty as Dr. Rabenhorst. Further, I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which Dr. Rabenhorst belongs.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Integrative Family Medicine, LLC may decline to provide treatment to me.



Signature of Patient/Legal Guardian

Date

Print Name of Patient/Legal Guardian

Jennifer Rabenhorst, MD

Date