BioFXN
Personalized Innovative Healthcare

Dr. Anna Martin, ND
Functional Medicine Doctor

Powered by Rebound SportsMed

Payment and Policies

Greetings,
We are very excited to begin your new health journey with you. This document will explain our expectations of you as our patient and let you know what to expect during your visit.

What to expect

Initial Office Visit
Initial intake office visits are a bit longer that follow up visits, which allows Dr. Martin to get to know you and address your health holistically. The first office visit is **60 minutes** in length.

During the first visit, Dr. Martin listens to your health concerns, gathers a complete and comprehensive medical history, performs relevant physical exams and may suggest additional laboratory tests. It is helpful for you to bring previous lab work (the last 5 years), any relevant imaging and all current medications and supplements to your first visit. You will walk out of this visit with specific treatment recommendations based on your individual needs. Depending on the nature of your complaint, physical therapy and treatment may also be completed in office during the first visit depending on time limitations and the nature of the complaint. Please wear comfortable, loose fitting clothing to your appointments, if at all possible, to allow for movement and treatment.

Dr. Martin practices using the least intervention for the greatest benefit: her protocols are designed to address your symptoms while she also creates a plan to address the cause of your illness. Dr. Martin's protocols are informed by evidence-based research on both natural and conventional therapies.

In most cases it will be worthwhile to have Dr. Martin review your intake and become familiar with your case before the initial visit. If requested, be sure to send the relevant documents to Dr. Anna Martin, ND in advance of your visit. You also might find it helpful in preparation for you to keep a journal, write a chronology or prepare a summary of your health complaints. If you have done so or can do so in advance of the initial visit, please send those documents as well so that you may have fully researched and considered advice, tailored to your specific concerns.

Cost of Services

Dr. Anna Martin has a cash practice, as many of the services she provides are not covered by insurance. Instead of the patient receiving a hefty bill for non-covered services, and the provider having to provide sub-par service due to insurance limitations...she bills for her time directly.

What this means to you?
You will only be billed for your time, in 30 minute increments. If Dr. Martin, chooses to use therapies or treatments in office, she will not bill extra for those services. For example, if she uses cold laser treatment or red light therapy on you during your visit, you will not be charged the extra $150 that we would usually bill for this service on top of the normal visit charge. Instead, it will be included in your normal visit charge. This treatment is not typically covered by insurance. The exception to this is products and supplements, equipment, and any type of injection. These are billed out at the normal retail cost. Technology or machines that are used outside of appointments are billed to the you separately. These costs, if any, will be discussed when prescribed in office.

How much are visits?
The charge for the initial office visit is $300 per hour, and future visits are $175 per half hour or $300 per hour, This includes a time of service discount of 20%. All fees are due at the time of service. We require a credit card on file for all patient appointments to hold your spot on the schedule. Dr. Anna Martin does not accept insurance, but can provide you with a superbill for you to submit to your insurance directly. The superbill does not ensure coverage, and we cannot help you with your claim submission or the claims process. If you are looking for a superbill to assist you with insurance reimbursement, you must verify your coverage with your insurance company at least 2 weeks before your initial visit and let us know prior to your visit that you will need a superbill after paying for your visit. Dr. Anna Martin, Bio FXN, PLLC and/or Rebound Sports Med are not in any way responsible for your insurance company's reimbursement of your claim nor can we guarantee coverage of your claim. Depending on the case, we may take a personal injury claim. However, you need to have our permission prior to your visit to do so.

What if I need to cancel?

Because Dr. Martin has limited hours available, we ask that all cancellations be made 48 business hours in advance. This means the Thursday before your Monday appointment, you would need to call to cancel. This allows us to fill the spot with another patient in need of care. The cost of a missed appointment will be the full cost of the scheduled visit. Late show visits past 15 minutes into an appointment will be rescheduled and charged the missed appointment fee. Please help us better serve all of our patients by writing down your appointment time, and giving us as much time to schedule another patient in your stead. Missed appointment fees will be charged to the card we have stored securely in your HIPAA privacy protected patient file. I thank you in advance for arriving with time to spare and allowing me to spend a full appointment addressing your concerns. You deserve the full allotted time! We look forward to meeting you and being part of your health journey!

Warmly,

Dr. Anna Martin, ND

Patient Acknowledgment: By signing my name below, I certify that I have received and read the office policies, cost of visits and procedures, and agree to comply with the information provided above. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand that I am financially responsible for all charges, including those submitted to an insurance company by a superbill. I agree to pay all services in full at the time of service. I understand that Dr. Martin's services are not covered by Medicare and these services may be offered by another practitioner who is covered by Medicare. I agree to pay all costs incurred by treatment with Dr. Martin. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

_____ _____
Patient (or Guardian) Signature Date

_____
Printed Name

Credit Card Information

Credit Card Number:_____

Expiration date:_____

Billing Zip Code:_____

3 digit CVV number on the back of your card:_____
Patient Acknowledgement: I acknowledge and accept these terms and conditions. I also agree to waive any charge back rights in the event of a dispute, and requests for a refund must be submitted in writing along with all documentation in accordance with standard policy of company issuing credit card. A receipt will be sent via email on the day the charge is made:_____(Initial)

Name:_____

Date:_____

Signature:_____

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Patient Registration
PLEASE WRITE LEGIBLY

Patient Name: _____

Last Name First Name Middle Initial

What is your preferred first name? (Nickname, Chosen name, etc.) _____

Other name(s) that records may be kept under:_____

DOB (required)_____ SSN:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email address:_____

Phone:

1. □ Cell □ Home □ Work: (_____)_____ **Confidential voicemail OK?** Yes No
2. □ Cell □ Home □ Work: (_____)_____ **Confidential voicemail OK?** Yes No

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The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Your answers are both voluntary and private.

What is your birth sex? □ Male □ Female □ Unknown □ Another: _____

What gender do you identify as? □ Male □ Female □ Trans □ Another: _____

What is your pronoun? □ He □ She □ They □ Another: _____

Primary Language:_____

Marital Status: □ Single □ Married □ Significant other □ Widowed

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Primary Care Provider (PCP) Information (Please select one of the following):

☐ I wish to establish Primary Care with Dr. Anna Martin, ND.

☐ I see Dr. Anna Martin, ND for ancillary/adjunctive care only. My Primary Care Physician (PCP) is: _____

☐ If seeking adjunctive cancer support, who is your oncologist? _____

- Last physical: _____ Date of Last bloodwork: _____

☐ Other providers: _____

Guarantor – *If different from the patient* (Person who is financially responsible for the account)

Name:_____ Relationship to the patient: _____

Address:_____

City:_____ State:_____ Zip:_____

Legal Guardian? □ Yes □ No SSN: _____ Gender: □ M □ F DOB:_____

Emergency Contact or Other Guardian/Parent Name: _____

Relationship: _____ Legal Guardian? □ Yes □ No

Primary Phone _____ Work Phone_____

Check if applicable: □ Auto Accident Date of Accident: _____ Claim#:_____

If you have an open personal injury claim and are wanting to use this as a form of payment, you must first receive permission from our office and fill out the personal injury intake forms.

Injury type and date. Please also include any additional information about the claim, other providers involved, and other treatments performed on the
claim:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Employment Status (Check one): □ Full Time □ Not Employed □ Part Time □ Retired □ Seasonal
□ Self-Employed □ Student (Full Time) □ Student (Part Time)

Employer_____

Address_____

How did you hear about us?

□ Friend/patient □ Event/health fair □ Shuttle/Bus □ Staff/student □ Physician: _____
□ Radio/TV □ Walk by □ Social media □ Yelp □ Website: _____

□ Please sign me up for the Clinic newsletter so I can stay up to date regarding clinic hours, events and discounts.

Research is vital to the advancement of natural medicine.
□ Yes! Please contact me for future research participation.

I certify the above information is true and correct to the best of my knowledge. I acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms on the payments and policies form.

_____ _____

Patient/Guardian Signature **Date**

PERSONAL HEALTH HISTORY for YOUR CLINICAL TEAM

Patient:_____Date of Birth:_____
Last Name First Name Middle Initial

What is the main reason, or goal, for your visit today? _____
_____

Allergies: Do you have a severe allergy to any of the following? (**Please select all that apply)**

☐ Sulfa	☐ Penicillin	☐ Aspirin	☐ Codeine	☐ Latex	☐ Sulfites
☐ Cats	☐ Dogs	☐ Mold	☐ Dust	☐ Bees	☐ Pollen
☐ Wheat	☐ Shellfish	☐ Peanuts	☐ Eggs	☐ Milk	☐ Soy

☐ Other _____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking.
If you need additional space to list medications/supplements, please use page 6 or the back of page 7.

Name of Medication/Supplement	Dose	Frequency Taken

Medical Conditions: Do you currently have or have a history of the following? **(Please select all that apply)**

☐ Adrenal Disorder	☐ Depression	☐ Inflammatory Bowel Disease
☐ Anemia	☐ Diabetes Mellitus	☐ Irritable Bowel Syndrome
☐ Anxiety	☐ Digestive Problem	☐ Kidney Disease
☐ Arthritis/Joint Disorder	☐ Heart Disease	☐ Liver Disease
☐ Asthma	☐ Hyperlipidemia	☐ Stroke
☐ Cancer	☐ Hypertension	☐ Thyroid Disease
☐ COPD		☐ Other:

Surgeries / Hospitalizations: (Please select all that apply and write in date.)

- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon Surgery
- ☐ Cosmetic Surgery
- ☐ C-Section (If applicable)
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy (If applicable)
- ☐ Joint Replacement
- ☐ Prostate Surgery (If applicable)
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation (If applicable)
- ☐ Valve Replacement
- ☐ Vasectomy (If applicable)
- ☐ Other:

Family History: Do you have a family history of any of the following?
(Please "X" the boxes that apply to you)

	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems	Other
Mother															
Father															
Sister															
Brother															
Maternal Grandma															
Maternal Grandpa															
Paternal Grandma															
Paternal Grandpa															
Maternal Aunt															
Maternal Uncle															
Paternal Aunt															
Paternal Uncle															
Other															

☐ Adopted ☐ Family History Unknown

Social History: Please answer the following questions regarding your social history:

Tobacco Use

Tobacco Use: ☐ Never Smoker ☐ Former Smoker ☐ Passive Smoke Exposure (Second Hand) ☐ Current Smoker
☐ Other
Start Date:_____ End Date:_____
Type of tobacco used: ☐ Cigarettes ☐ Cigars ☐ Pipe
Packs/Day:_____ Years:_____
Smokeless Tobacco: ☐ Current User ☐ Former User ☐ Never Used ☐ Unknown
Types: ☐ Snuff ☐ Chew
Quit Date (if applicable):_____
If you are a current tobacco user: Are you ready to quit? ☐ Yes ☐ No

Do you drink alcohol?	☐ Yes	☐ No

If Yes, how many of the following do you have per week?
Drinks/Week: Glasses of Wine_____ Cans of Beer_____Shots of Liquor_____

Do you currently use any of the following recreational or street drugs? (Please select all that apply):

☐ E-Cigs	☐ Marijuana	☐ Opioids	☐ Heroin
☐ Methamphetamine	☐ Amphetamines	☐ PCP	☐ Ecstasy
☐ LSD	☐ Ketamine	☐ Mescaline	☐ Psilocybin
☐ Cocaine	☐ Crack	☐ Nitrous Oxide	☐ Solvent Inhalants
☐ Barbiturates	☐ Benzodiazepines	☐ IV	☐ Other

If yes to Marijuana: □ Medicinal? □ Recreational? □ Both?
If yes to any of the drugs above how many times per week estimate do you use them? _____

What is your current birth control method? (Please select all that apply):

Sexually Active: ☐ Yes ☐ No

Birth Control/Protection:

☐ Abstinence	☐ Cervical Cap	☐ Condom	☐ Hormonal Patch
☐ Implant	☐ Injection	☐ Inserts	☐ IUD
☐ IUS	☐ Pill	☐ Rhythm	☐ Spermicide
☐ Sponge	☐ Surgical	☐ Vaginal Ring	☐ Withdrawal
☐ Vasectomy	☐ Menopause	☐ None	☐ Other

Partners? ☐ Male ☐ Female ☐ Both ☐ Another

Sexual Orientation/Gender Identity (this helps our clinicians give you the best care possible)**:**

What is your birth sex?	☐ Male	☐ Female	☐ Unknown	☐ Another:_____
What gender do you identify as?	☐ Male	☐ Female	☐ Trans	☐ Another:_____
What is your pronoun?	☐ He	☐ She	☐ They	☐ Another:_____

Do you have any children? Yes No If so, what are their ages:

Do you exercise regularly? Yes No If so, how often and what type of exercise?

Do you have any dietary restrictions or food intolerances? Yes No If so, what?

Additional Medications/Supplements?

Name of Medication/Supplement	Dose	Frequency Taken

CONTINUED ON NEXT PAGE

Review of Systems: **Please circle below if you've experienced in the last six months:** **Y= Yes N= No**

Constitutional

Fever	Y	N	Chills	Y	N	Weight Loss	Y	N
Malaise/Fatigue	Y	N	Sweating	Y	N	Weakness	Y	N

Skin

Rash	Y	N	Itching	Y	N	Color changes	Y	N

Head, Ears, Eyes, Nose, Throat

Headaches	Y	N	Hearing Loss	Y	N	Ringing in Ears	Y	N
Ear Pain	Y	N	Ear Discharge	Y	N	Nosebleeds	Y	N
Congestion	Y	N	Migraine headaches	Y	N	Sore Throat	Y	N

Eyes

Blurred Vision	Y	N	Double Vision	Y	N	Light Sensitivity	Y	N
Eye Pain	Y	N	Eye Discharge	Y	N	Eye Redness	Y	N

Cardiovascular

Chest Pain	Y	N	Palpitations	Y	N	Shortness of breath lying down	Y	N
Claudication	Y	N	Leg Swelling	Y	N	Heart Murmur	Y	N
High blood pressure	Y	N	Blood clots	Y	N	Heart disease	Y	N

Respiratory

Cough	Y	N	Coughing up Blood	Y	N	Sputum Production	Y	N
Shortness of breath	Y	N	Wheezing	Y	N	Asthma	Y	N

Gastrointestinal

Heartburn	Y	N	Nausea/Vomiting	Y	N	Abdominal Pain	Y	N
Diarrhea	Y	N	Constipation	Y	N	Blood in Stool/black stool	Y	N
How many Bowel Movements per day:			Bloating	Y	N			

Genitourinary

Painful Urination	Y	N	Urgency	Y	N	Frequency	Y	N
Blood in urine	Y	N	Flank Pain	Y	N	Incontinence	Y	N

Male Reproductive

Hernias	Y	N	Testicular masses	Y	N	Sexual difficulty	Y	N

Female Reproductive

Age of first menses:	Age of last menses:	Number of pregnancies:
Number of live births:	Number of miscarriages:	Number of abortions:

Musculoskeletal

Muscle Pain	Y	N	Neck Pain	Y	N	Back Pain	Y	N
Joint pain	Y	N	Falls	Y	N	Muscle spasms	Y	N

Endocrine/Heme/Allergies

Excessive thirst	Y	N	Env. Allergies	Y	N	Easy Bruising/Bleeding	Y	N
Cold intolerance	Y	N	Excessive hunger	Y	N	Heat intolerance	Y	N

Neurological

Dizziness/fainting	Y	N	Loss of memory	Y	N	Tremor/Seizures	Y	N
Sensory Change	Y	N	Speech Change	Y	N	Numbness/tingling	Y	N

Emotional (Psychiatric)

Depression	Y	N	Suicidal Ideas	Y	N	Substance Abuse	Y	N
Hallucinations	Y	N	Nervous/Anxious	Y	N	Insomnia	Y	N

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Waiver of Liability

Male____ Female____

_____ _____
Last Name First Name

(_____)_____ _____
Phone (circle one) Home Cell Work Email Address

_____ _____
Address City State Zip Code

Date of Birth_____ Occupation_____

_____(_____)_____ _____
Emergency Contact Phone # Relationship

HEALTH CONDITION

Past _____How long_____

Present _____How Long_____

How did you hear about BioFXN, PLLC_____

WAIVER OF LIABILITY

I am participating in BioFXN, PLLC services, seminars, classes and/or private training offered by BioFXN, during which I will receive information and instruction about BioFXN's services, offerings, fitness & wellness. I recognize that the BioFXN services, programs and offerings require physical exertion and other services which may be strenuous, and/or may cause physical injury, and I am fully aware of the risks and hazards involved. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in any BioFXN services or offerings. I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in BioFXN services or offerings. In consideration of being permitted in the BioFXN services or offerings, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the BioFXN services or offerings. I also agree to take full responsibility for not exceeding my limits in when using the BioFXN services or offerings. I acknowledge that practitioners and/or instructors may physically adjust positions of participants during BioFXN services or offerings. If I do not want physical adjustments, I will inform the practitioner/technician/trainer/instructor at each service or offerings I attend. I am also aware that the BioFXN utilizes equipment which requires extra attention on my part not to misuse or overuse. In consideration of being permitted to participate in BioFXN services or offerings, I knowingly, voluntarily, and expressly waive any claim I may have against the BioFXN for injury or damages that I may sustain as a result of participating in BioFXN services or offerings. I, my heirs or legal representatives further release, waive, discharge and covenant not to sue or bring any legal action against BioFXN for any injury of any sort caused by my negligence or other acts, or my participation in BioFXN services or offerings. I have read the above and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

_____ _____
Date Signature

If participant is under 18, as legal guardian I consent to the above terms and conditions. _____
Guardian Name

_____
Signature

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CONSENT FOR TREATMENT

***General Information*:** Dr. Anna Martin, ND will supervise your medical care. She has preceptors and technicians that work with her to ensure that you receive the best care possible. Student clinicians, or technicians, depending on their levels of experience, may observe or participate in the care provided but are always supervised by healthcare providers licensed in the State of Washington. Your medical history, treatment plan and progress is discussed (without identifying information) among other student clinicians for educational purposes at the clinic and evaluated by the supervising faculty for appropriateness and effectiveness. Due to the diversity of modalities offered at BioFXN and Rebound SportsMed, your treatment may include any or all of the following general modalities: Naturopathic Medicine, Physical Medicine, Botanical Medicine, Environmental Medicine, IV therapy and injections, Clinical Neurology, Homeopathy, Minor Office Procedures, Psychological Counseling and Nutritional Counseling.
Dr. Martin often uses multiple treatment modalities in the length of one visit. All of our medical practitioners are licensed in the State of Washington having completed graduate level training and national board certification.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform general diagnostic procedures, psychological counseling, lifestyle counseling, exercise prescriptions, dry needling, topical treatments, IV therapy and injections, herbal medicine, environmental medicine, natural medicine, clinical neurology assessment and therapy, dietary advice and therapeutic nutritional counseling, soft tissue and osseous manipulation, electromagnetic and thermal therapies and movement therapies.

Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

- General Diagnostic Procedures: including but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.
- Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
- Dry needling/Trigger Point Injection: e.g. insertion of special sterilized needles or lancets at specific points on the body with or without solution.
- Topical Treatments and Prepping: e.g. massage cupping (a technique using massage cups on the surface of the skin with usually a suction created vacuum and oil)
- Herbs/Natural Medicines: e.g. prescribing therapeutic substances which include plants, minerals. animal materials and other nutraceuticals. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
- Dietary Advice and Therapeutic Nutrition: e.g. use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.
- IV Therapy: e.g. use of vitamins, minerals and nutraceuticals in an IV.
- Oral chelation: e.g. use of a chelator to reduce toxic burden
- BHRT/Other hormone therapy: e.g. bioidentical hormone replacement therapy and other hormone therapy such as contraceptives as deemed medically necessary by healthcare provider
- Clinical Neurology Assessment &Treatment: including but not limited to use of clinical neurology diagnostic procedures, vestibular rehabilitation , core and balance training, optokinetic training, and cognitive training
- Minor Office Procedures: e.g. cleaning, suturing, and dressing a wound, ear lavage, skin scraping, superficial removals, skin cryotherapy
- Vaccinations and Pharmaceuticals: e.g. use of vaccinations and pharmaceuticals as deemed medical necessary by the healthcare provider. Alternate vaccine schedules, exemptions as well as single vaccines may be options if deemed medically necessary.
- Soft Tissue and Osseous Manipulation: e.g. use of massage, vibration, fascial manipulation, neuro-muscular techniques, muscle energy stretching, visceral manipulation, Stecco FM as well as manipulations of the extremities and spine including manual manipulation, SOT, The Activator Method, traction, decompression, and craniosacral therapy.
- Electromagnetic Light and Thermal Therapies: e.g. ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, sauna, diathermy, thermal imaging and infrared and ultraviolet therapies, low level laser and colored light therapies.
- Potential Risks: While not common, can potentially occur from any therapy. Some examples include but are not limited to: pain, discomfort, blistering, discolorations, infection, or burns from topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; loss of consciousness or deep tissue injury from needle insertions or needle breakage; allergic reactions or side effects to prescribed IV therapies, injections, vaccinations, pharmaceuticals, herbs or supplements; soft tissue, nerve, vessel or bone injury from physical manipulations; and aggravation of pre-existing symptoms. In addition, the patient must inform the practitioner if the patient has a severe bleeding disorder, malignancies, pacemaker or metal implants prior to any treatment.

- ***Potential benefits:*** Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, palliation of symptoms, assistance in injury and disease recovery and prevention of a disease or its progression.
- ***Notice to Pregnant Women:*** All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

I understand that Washington State law does not authorize naturopaths to treat me for any **cancer or malignancy** and that I am required to be under the care of a medical doctor or osteopathic physician (oncologist) while receiving care with Dr. Anna Martin, ND. I recognize that I am here for supportive therapies only. I understand that Dr. Anna Martin, ND does not prescribe schedule 1 or 2 controlled substances. If Dr. Anna Martin decides these are medically necessary, she will refer you to another practitioner.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Anna Martin ND, BioFXN, Rebound SportsMed or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. **I hereby acknowledge that I am financially responsible for all services rendered.**

_____

Signature of patient

_____

Date

_____

Signature of guardian

_____

Date

_____

Relationship to patient

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FINANCIAL AGREEMENT

What you should know:

By signing this agreement, you have agreed to pay for your services in full at the time of service.

Nonpayment

If your payment is returned or denied and you have not paid your bills within 30 days after receiving your final notice you will be turned over to a collection agency. You will be responsible for any collection agency fees that apply. You may be reported to a credit bureau and denied additional services with Dr. Anna Martin, ND, BioFXN and/or Rebound SportsMed.

Questions? Please contact our Billing Office at 253-854-8880, if you have any questions about anything in our policy.

NOTICE OF PRIVACY PRACTICES

Acknowledgement

Dr. Anna Martin, ND is required to provide you with a copy of her Privacy Policy and to obtain written acknowledgement, if possible, that you have received it. You can review our privacy policies below. A parent or guardian should sign for patient under age 18. If you have questions concerning the management of your healthcare information at our clinic, or if you wish schedule an appointment to view your medical record, please call our medical records office at 253-854-8880.

I understand that communication via email is unsecured (messages sent via the patient portal are secure) BioFXN, PLLC, Dr. Anna Martin and Rebound SportsMed's office cannot guarantee the privacy or confidentiality of information transmitted via email. This extends to any attachments sent via email. Additionally, while BioFXN, PLLC, Dr. Anna Martin and Rebound SportsMed's office may use email to assist with scheduling and billing related issues, I understand that email is not to be used for health care concerns, emergencies or crises. Email communication cannot take the place of clinical appointments and will not be used for extended clinical discussions.

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic. I understand that if I have an open personal injury claim that I am financially responsible for all charges whether or not they are paid by my claim. I hereby authorize BioFXN, PLLC and Rebound SportsMed to release all information necessary to secure the payment of any claim on my behalf, and I authorize the use of this signature on all claim submissions. I further acknowledge that I have received a copy and have read and understand Dr. Anna Martin's Privacy Policy.

_____

Signature of patient

_____

Date

_____

Signature of guardian

_____

Date

_____

Relationship to patient

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Privacy Policy

BioFxn, PLLC protects the privacy of your medical information.

To obtain a copy of your personal medical records, contact our Medical Records office. If you have questions concerning this notice, please ask to speak to the medical records manager.

Rebound SportsMed

11107 Kent Kangley Rd

Kent, WA 98030
253-854-8880 Phone
425-249-7535 Fax

Patient forms, including Authorization to Release Confidential Health Information, are available for download on our website.

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.

Who Will Follow This Notice

This joint notice describes the practices of:

- Any health care professional authorized to enter information in your medical record at BioFxn, PLLC and Rebound SportsMed. This includes employees and contracted medical

staff. BioFXN, PLLC and its non-employee medical staff have formed an organized health care arrangement so that BioFXN, PLLC and its independent providers may share your health information with each other as necessary to carry out treatment, payment, and operations. Your independent provider may have separate privacy practices for care delivered separately than BioFXN, PLLC.

- All department personnel of BioFXN, PLLC that comprise BioFXN, PLLC's health care component. This includes all personnel of the BioFxn, PLLC, BioFXN, PLLC's Research Department, all preceptors or student clinicians and Rebound SportsMed.

Our Responsibilities

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information related to these services. Federal and state laws allow us to use and disclose your protected health information for purposes of treatment, payment, and health care operations.

How We May Use and Disclose Medical Information About You

BioFXN, PLLC is part of an organized health care arrangement including participants in Practice Fusion EHR. As a business associate of BioFxn, PLLC Practice Fusion EHR supplies information technology and related services to BioFXN, PLLC and other participants. Practice Fusion also engages in quality assessment and improvement activities on behalf of its participants. For example, Practice Fusion coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. Practice Fusion also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by BioFXN, PLLC with other Practice Fusion participants when necessary for health care operation purposes of the organized health care arrangement."

For Treatment: Information obtained by a licensed provider, student clinician, or other member of our healthcare team will be recorded in your electronic medical record and used to help decide what care may be right for you. For example, your physician may need to consult with specialists about your care. Information about you would be shared with other providers to help understand your care needs.

Communication with Family and Friends: We may release medical information about you to a family member or friend who is involved in your care and/or helps pay for your care. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at our clinic.

Health Information Exchange: The electronic health record is included in the PRACTICE FUSION, EHR collaborative. If you do not want your records to be a part of this collaborative than we will not be able to serve you. We can assist you in finding another provider that can accommodate your request.

For Payment: When we request payment from other payers on your behalf, they need information from us about your medical care such as diagnoses, procedures performed, or recommended care in order to cover the services provided to you. For example, we may need to give your personal injury claim information about physical medicine therapy you received so your claim will pay us or reimburse you for the procedure. We will not disclose your health information to third party payers without your authorization unless allowed to do so by law.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example:

- We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- We may disclose information to physicians, student clinicians, medical assistants, technicians, or other clinic personnel for review and learning purposes.
- We may use and disclose your information to conduct or arrange for services, including medical quality reviews; accounting, legal, risk management and insurance services; and audit functions, including fraud and abuse detection and compliance programs.

Other Uses and Disclosures

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may tell you about health related benefits, services, or health care education classes that may be of interest to you.

Fundraising: We may contact you as a part of a fund raising effort. If we contact you, we will also provide you with a way to opt out of receiving future fundraising request. We will not use your medical records information for fundraising purposes.

Research: We may disclose information to researchers when an institutional review board has approved the research proposal and established protocols to ensure the privacy of your health information. In most circumstances, we will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are.

Limited Data Sets Member authorizes PRACTICE FUSION, EHR to create Limited Data Sets of Member information for certain research activities consistent with applicable law ("Activities") which may require access to such Limited Data Sets. PRACTICE FUSION, EHR may disclose Limited Data Sets to third party researchers, provided that PRACTICE FUSION, EHR obtains and maintains with each such third party researcher an agreement that is consistent with the requirements for Limited Data Set use agreements under HIPAA.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.

Special Situations

Organ and Tissue Donation: If you are an organ donor, we may release medical information as necessary to facilitate organ or tissue donation and transplantation to organizations that handle organ or tissue procurement and transplantation or to an organ donation bank.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health: As required by law, we may disclose medical information about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our clinic;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official necessary for your health and the health and safety of other individuals.

Your Health Information Rights

Right to this Notice: You have a right to a paper copy of this notice. You may ask us to give you a copy at any time.

Right to Inspect and Copy: You have a right to inspect and receive a copy of certain health care information including certain medical and billing records. To obtain a copy of your records you must submit your request in writing to our Medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If you would like to schedule an appointment to view your record or if you any questions about you right to inspect and copy your record, please contact the Medical Records at (253) 854-8880 .

Note: We are required to retain our records of the care that we provided to you. Although you have the right to exercise control over certain uses and disclosures of your medical information, the medical record BioFXN, PLLC maintains on your care is property of BioFXN, PLLC. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical record, you may request that the denial be reviewed. We will comply with the outcome of the review.

Right to Request Amendment: You have a right to ask that your health information be amended by sending a written request to our Medical Records Department. We have the right to deny this request under certain circumstances. You may write a statement of disagreement if your request is denied. This statement of disagreement will be stored in your medical record, and included with any release of your records.

Right to a List of Disclosures: You have the right to request a list of disclosures. This is a record of certain disclosures we made of medical information about you in accordance with applicable laws.

You must submit your request in writing to our Medical Records Department to obtain a list of disclosures. The first time you request a list within a 12-month period will be free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restriction: You have a right to ask us to restrict certain uses and disclosures of your health information. You may be asked to make this request in writing. Ask your caregiver if you have questions about this. We will comply with all reasonable requests.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a specific way or location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may be asked to make your request in writing. Ask the person (or department) that gave you this notice for more information about this process. We will comply with all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Revoke Authorization: Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you under these circumstances, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and information disclosed to other party's may no longer be afforded certain protections under the law once released and might be re-disclosed to other parties without your authorization.

Changes to this Notice

We reserve the right to change this notice at any time. Any revised or changed notice will be 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 clinic and on our website, www.biofxn.com/Patientforms.

Complaints

If you believe your privacy rights have been violated, you may contact BioFXN, PLLC's Medical Records Department Manager/HIPAA Compliance Officer at: 11107 Kent Kangley Kent, WA 98030; [(253) 854-8880]. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

Authorization to Release Health Care Information

BioFXN
Personalized Innovative Healthcare
Dr. Anna Martin, ND
Functional Medicine Doctor
Powered by Rebound SportsMed

Instructions

Failure to follow instructions can result in a delay in processing your request.

1. Print name of patient, birth date and Social Security number of patient for whom the medical records are being requested.
2. Print name of physician, provider, or organization or person that is being asked to disclose copies of the records.
3. Print name, address and phone number of organization or person that is to receive the copies of the information.
4. Check box(s) to indicate what information is to be disclosed:
   a. Information for most recent 2 years of visits.
   b. All outpatient visits for the specific time frame indicated.
   c. All records related to the course of treatment, diagnosis, procedure or condition indicated, form request, other.
   d. Email communication
5. Check the box that applies to the reason the records are being requested.
6. Sign and indicate date signed.
7. Minors between ages of 13 and 17 must authorize the release of certain information concerning the minor.
8. Indicate date for the authorization to expire if it is to be different than 90 days from date of signing.

Charges

There is no charge for copying your medical records if you have the copies sent directly to a health care facility or provider for continuing or transfer of care. If you are requesting copies of medical records for yourself, you will get the first six pages free of charge. Additional pages will result in a copy fee being applied. In addition, postage and sales tax may be charged. You may be invoiced or required to pay applicable fees prior to obtaining the copies. Payment is otherwise due upon receipt of your copies. If charges exceed $25, payment may be required prior to receipt. Information disclosed pursuant to this authorization will not be redacted. Additional fees may apply if redaction is required.

Contact us at (253) 854-8880 to request your copies of your medical record, for information about copy charges and/or questions related to copying health information from your medical record.

Authorization to Release Health Care Information

BioFXN
Personalized Innovative Healthcare
Dr. Anna Martin, ND
Functional Medicine Doctor
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1. Individual information:

Patient name: _____ SS#: _____ - _____ - _____ Date of Birth _____ / _____ / _____

2. Information may be disclosed by:

Name of provider, or organization releasing information: _____

Address: _____ Suite/Apt#: _____

City: _____ State: _____ Zip: _____

3. Information may be disclosed to:

Name of organization or person to receive information: _____

Address: _____ Suite/Apt#: _____

City: _____ State: _____ Zip: _____

Daytime phone: (_____)_____ Fax: (_____) _____

4. What kind of information do you want disclosed? (Check box, copy fees may apply)

☐ All records from the last 2 years of visits

☐ Information from date _____ / _____ / _____ to date _____ / _____ / _____

☐ Email Communication: _____

☐ Other: _____

5. Why are you asking for this health information to be released? (Check ***one*** box)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Medical leave ☐ Personal ☐ Other _____

Authorization

Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for this information to be released.

_____ initial

Rights

Generally, BiofXN, PLLC and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing. Once the information I have authorized to be disclosed is disclosed, it may no longer be protected under health information privacy laws. If I revoke my authorization, it will not affect any actions already taken by BiofXN, PLLC based upon this authorization.

Signatures

_____ _____

Patient or Guardian, or Authorized Representative **Date**
(Documentation may be required to prove authority to sign on behalf of the patient)

_____ _____

Minor Signature (requied if minor is age 13-17) **Date**

This authorization expires 90 days from the date signed ***or*** on the date or event indicated here: _____