Consulting Practice of Dr. Kurt N. Woeller & Dr. Tracy Tranchitella

Welcome!

Thank you for choosing the health consulting practice of Dr. Kurt N. Woeller and Dr. Tracy Tranchitella. We are dedicated to making your experience a most satisfying one and each doctor will work hard to provide you and/or your child the type of care that is specifically tailored to your needs.

The information enclosed in this packet is necessary for us to complete your file and for our participation in your health care education. You are encouraged to keep copies of these documents for your records.

NOTE: The following forms must be completed, signed, and received by our office prior to scheduling a consultation with the doctors. We apologize for any inconvenience this may cause, but we need to accommodate other individuals waiting to be scheduled. **You may fax, mail or email these forms to the addresses or fax number below:**

750 NW Charbonneau Street, Suite 201, Bend, OR. 97701
Phone: 951-461-4800 Fax 951-461-4560 email: SCMedicalCenter@gmail.com

1. **Consultation Information Document Packet** (includes Contact Information Form, Practice Policies and Procedures, Notice and Consent of Privacy Policy, and Credit Authorization Form) – *return*
2. **Dr. Woeller and Tranchitella Consultation Informed Consent Form** *(return)*
3. **Health History Questionnaire** *(return)*
4. **Arbitration Agreement** (return)

If your initial appointment is at one of the office suite locations with Drs. Woeller and Tranchitella, and it is your child who is seeing the doctor, please bring an adult to look after them as the doctor will need your full attention for much of the consultation. If your initial health education consultation is by phone or internet it is still a good idea to have another adult tend to your child so your consult remains uninterrupted.

If you have copies of recent medical and laboratory reports, please provide them to our office at least 48 hours prior to your consultation. This provides us enough time upload the files and to have the doctors review them prior to your appointment.

Please don't hesitate to contact us should you have any questions. We look forward to assisting you.

Consulting Practice Policies and Procedures

Hours of Operation:

- Monday through Thursday 9 am to 1 pm (Pacific Standard Time)
- Consults are by appointment only

Payment:

Payment in full is due on the date of service. We accept cash, check, Mastercard, Visa, American Express, and Discover. For individuals needing a payment plan we accept CareCredit (see below):

- ***CareCredit:***

  CareCredit (www.carecredit.com) is a health financing service that you can put towards consultations and laboratory testing. Our practice is listed as ***Sunrise Complementary Medical Center*** under ***General Medicine*** on the ***CareCredit*** website.

We can provide you with an insurance receipt called a Superbill to submit to your insurance company for reimbursement for services rendered. Make sure to email our office at SCMedicalCenter@gmail.com for an insurance code receipt if this is something you want.

Please be aware that the doctors do not accept insurance reimbursement and are not participating members in Medicare, Medicaid, Tricare, and Worker's Compensation. They are not members of any HMO or PPO.

Credit Card "On File" Policy:

- We may charge a fee between $5.00 and $50.00 for correspondence regarding responses to e-mails, faxes, and new or existing prescription requests. The fee is based on the volume of questions and the research involved in getting the questions answered for you.
- It is helpful to our practice if you leave a credit card on file. With your permission, we are able to charge for in-person, phone and internet consults, email correspondence, documentation requests, i.e. Medical Letters, Narrative Reports, Chart Note Copying, extra copy of receipts, etc.
- If you gave us permission to keep your credit card on file, please let us know if we should call you each time before running the card for any of the charges listed above.

Appointments:

- Because of the busy nature of our practice we require a $100.00 deposit for new patients. You may use VISA, MC, Amex or Discover. The deposit will be applied to the cost of the visit. If a "No Show" or late cancellation occurs the deposit will no longer apply to the visit (see cancellation policy below).

- **Paying by check** – your check must be received prior to your scheduled appointment. Otherwise, your consultation time will need to be changed unless a credit card on file can be used to pay for the appointment.
- Initial consultations are usually scheduled for 30 to 45 minutes based on the nature and/or complexity of your situation. Follow-up consults can range from 15 to 60 minutes depending on the complexity of your case including lab review, etc.

Consultation Types:

- Both doctors provide in-person, phone and internet consultations.
- There is no price difference for phone or skype.com (aka. internet) consultations. Each phone consultation is treated like any other consultation – *the time spent with your doctor is the same whether it is in person or over the phone or computer.*
- Your doctor will call, or contact you via the internet at the time of your scheduled consultation.
- All appointments are scheduled for the Pacific Standard Time zone.
- We require patients outside of the USA to call the office at the time of their scheduled phone consultation (unless other arrangements are made). If this is not possible, than phone consultation phone bill charge will be billed to the client. If your consult is via skype.com (aka. Internet), the doctor will contact you at the time of the consult.

Cancellations:

- We would appreciate at least 72 hour notice for new patients canceling an appointment and a 24 hour notice for established individuals. Otherwise there will be a $100 charge for new consults and $50 charge for established consults for the missed appointment.

Prescriptions:

- Due to the potential risk of error, we request that you do not make telephone requests for prescription refills. Please fax or email prescription requests to **951-461-4560 (fax**) or SCMedicalCenter@gmail.com. It is best to have your pharmacy fax a refill request directly to our office. The doctor will review your request and your medical file then respond as appropriate.
- If it has been more than a year since your last in-person consultation with your doctor a follow-up in-person appointment may be necessary.

- Prescriptions originating from a consultation are processed at no charge. If you have not seen the doctor in a year or more, refills of these original prescriptions requested by you that are approved by your doctor without consultation can incur a processing charge per prescription.
- Requests for a new prescription, a change in medication or transfer to a different pharmacy can also incur a prescription processing charge. These fees will range from $10 - $25.

Emergency:

- Due to the consultative nature of our practice, we are unable to offer round-the-clock emergency availability. Should you have a medical emergency, please go to the nearest emergency facility for care.
- We request that you maintain a primary care physician (i.e., family physician, pediatrician, Internist) for your regular medical needs. The doctor's goal is, to the best of their ability, to help you or your child overcome your chronic health issues.

Acceptance of Policies and Procedures

By completing the following you agree to the policies and procedures detailed above.

Patient (please print):_____ Date: _____

Signature (patient or responsible party): _____

If signed by party other than patient, print name: _____

Sunrise Complementary Medical Center

(consulting practice of Drs. Woeller and Tranchitella)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 Privacy Officer Leigh Woeller

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.

It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Leigh Woeller at (951) 461-4800 or SCMedicalCenter@gmail.com for further information about the complaint process.

This notice was published and becomes effective on: **5/1/2016**

Acknowledgement and Consent of Notice of Privacy Policy

I understand that **Kurt N. Woeller, D.O. and Tracy Tranchitella, N.D.** and **their mutual practice (referred to below as "This Practice")** will use and disclose **health information** about me. I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my or my child's care and treatment; refer to, consult with, coordinate among, and manage along with other health care providers for my or my child's care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my doctor's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Policy** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Policy may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Policy. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Policy in effect will be posted on This Practice's website – www.mysunrisecenter.com. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Policy, and I understand that This Practice is not required by law to agree to such request. By signing below, I agree that I have received and understand the information above and that I have reviewed the Notice of Privacy Policy on This Practices website.

By: _____ Date:_____
(Patient)

-OR_
By: _____ Date:_____
(Patient Representative)
Description of Representative's Authority:_____