Consent to Care and Financial Agreement

CONSENT TO PROVIDE CARE

I wish to receive consultative services from holistic clinical pharmacist, Cathy Rosenbaum, PharmD, MBA, RPh. I therefore give my consent to care and authorize her to recommend dietary supplements including herbal products, vitamins, other nutraceuticals, lifestyle tips via her seven balance point model for health, and/or questions for my primary care physician, as are in her judgment able to enhance my well-being. I understand the following statement regarding my use of dietary supplements and manufacturers' labeled product claims: **"DISCLAIMER: These statements have not been evaluated by the Food and Drug Administration. Products mentioned are not intended to diagnose, treat, cure or prevent any disease. Information and statements made are for educational purposes and are not intended to replace the advice of your health care professional."** I understand the practice of holistic medicine, including referrals to qualified non-traditional medicine practitioners, is not an exact science, and acknowledge that no guarantees are being made to me as a result of my evaluation and/or referrals by Dr. Rosenbaum.

Client Signature Witness Date

AUTHORIZATION TO RELEASE INFORMATION

I agree that records concerning my condition and care may be kept on file. I agree that all medical or other information about me which has been acquired in the past by Dr. Rosenbaum and any information relating to this care may be released or disclosed, from time to time, to any physicians, other healthcare professionals, or non-traditional medicine practitioners who may be caring for me.

I (as a patient or agent of the patient) hereby authorize Dr. Rosenbaum to permit access to and/or release medical information, including copies of such information, to any physicians, other healthcare professionals, or non-traditional medicine practitioners caring for me. I understand that it is the standard practice of Dr. Rosenbaum to communicate with my primary care physician, specialty care physicians, or non-traditional medicine practitioners only with my written permission.

Client Signature Date

FINANCIAL AGREEMENT

I understand that payment for the services to be rendered by Dr. Rosenbaum is my responsibility and I agree to pay all charges at the time of the service by way of personal check or money order only. With regret, credit cards are not accepted. I understand that Dr. Rosenbaum's services are not covered by third party payers or Medicare. I further understand that Dr. Rosenbaum does not receive reimbursement from Medicare/Medicaid and that I am responsible for all charges at the time of service.

Client Signature Date

Effective February 1, 2005
Last Revision January 1, 2012

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DETAILS HOW YOUR MEDICAL INFORMATION MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Rx Integrative Solutions, Inc. which is covered by regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is required by law to maintain the privacy of your health information, give you notice of our privacy practices with respect to your medical information, and follow the terms of this notice. This notice applies to all of the records of your care generated and maintained by Rx Integrative Solutions, Inc.

How Your Medical Information May Be Disclosed

We may use your medical information to provide you with consultative services.

We may use and disclose your medical information so that payment may be collected from you. For example, we may need to give your information to our billing department.

We may disclose your medical information to contact you as a reminder that you have an appointment for services.

We may disclose your medical information to recommend you schedule an appointment with a physician, when necessary, to prevent a serious threat to your health and safety.

We may use your name and testimony from the patient satisfaction survey in company marketing and advertising, only with your written permission.

Other disclosures of your medical information not covered by this notice will be made only with your written permission. You may revoke that permission in writing at any time.

You have the right to inspect and obtain a copy of your medical information.

If this privacy policy changes, the revised policy will be made available to you at the time of service. You have the right to a copy of this notice.

I have reviewed the Rx Integrative Solutions Privacy Policy, understand, and agree to its contents.

Full Name_____

Date_____

Effective February 1, 2005
Last Revision January 1, 2012