ANATARA
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san francisco stem cell
TREATMENT CENTER

Informed Consent and Request for Care

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Anatara Medicine/San Francisco Stem Cell Treatment Center, (SFSCTC)/Spirit Medical Group, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I,_____, hereby request and consent to examination and treatment with Anatara Medicine/SFSCTC/Spirit Medical Group, and all Practitioners and staff hereafter called The Practice. These treatments at The Practice include herbs, homeopathy, chelation, Ultraviolet Blood Irradiation Therapy, Oxygen, Prolozone, Ozone Therapy, cancer care support, Ozone Sauna, Pulsed Magnetic Field Therapy, Trigger Point Injections, Intravenous therapies and nutrients, supplements, massages, nutritional advice, and more.

I understand that I have the right to ask questions and discuss to my satisfaction with The Practice regarding:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that an evaluation and treatment at The Practice may include, but are not limited to:

- Physical exam including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments
- Common diagnostic procedures including venipuncture, PAP smears, imaging, laboratory
- Evaluation of blood, urine, stool and saliva
- Soft tissue and osseous manipulation
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/ herbal medicines
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications
- Cancer Care support to include Insulin Potentiation Therapy

The scope of practice of Classical Chinese Medicine is outlined below. I understand that Classical Chinese medicine evaluation and treatment may include, but are not limited to:

- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials).

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms; anaphylactic reaction; seizure; cardiac arrest; and even death.

Notice to pregnant women or women of child bearing age: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. It is the responsibility of the patient to notify the office if there is a chance of pregnancy.

Notice to patients with bleeding disorders, pace makers, and/or cancer: For your safety, it is vital to alert your provider at The Practice of these conditions.

_____I understand that physicians at The Practice will only prescribe medications if he/she believes that they are in my best interest.

_____I understand the US Food and Drug Administration have not approved most of the services provided at The Practice as well as nutritional, herbal and homeopathic substances.

_____ I understand the possible side effects, complications, and problems associated with the services I am requesting, and that not all potential risks are listed in this consent but before receiving any treatment, I have consented to that treatment and all my questions have been answered to my satisfaction prior to my proceeding with any treatment.

_____ I understand and state that no promises or assurances of definite improvement or resolution have been made by the healing partners or staff. I understand that I can discontinue my chosen approaches at any time and my healing partner will not be prejudiced against me in any way. I believe the risks of my chosen service(s) to be less than the risks of conventional treatment for my condition.

I do not expect The Practice to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the practitioners at The Practice explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____	_____	_____
Signature of Patient	Printed Name of Patient	Date
_____	_____	_____
Signature of Guardian	Printed Name of Guardian	Date

Credit Card Authorization Form and Cancellation Policy

Patient's Name: _____ Name on Credit Card: _____

Credit Card Number Ending: _____Expiration: _____

Credit Card Number Ending: _____Expiration: _____

Billing Address:

_____

I certify that I am authorized to use this credit card.

Explanation of Payment and Cancellation Policy:

Payment is due at the time of service. We are an out-of-network provider, meaning we do not accept any insurance for payment for services.

I authorize Anatara Medicine, San Francisco Stem Cell Treatment Center, and Spirit Medical Group to keep my credit card on file and bill my credit card for payment of services, laboratory testing and/or supplements. _____I agree.

If I request that my labs drawn at this office are performed and billed to your office directly, I understand that once the bill comes through to your office, I am giving you permission to automatically charge my credit card on file. _____I agree.

If it is necessary to cancel your scheduled appointment, we require that you call 24 hours + in advance. Failure to notify our office 24 hours in advance may results in a charge equal to the fee of the scheduled treatment.

Please be advised that we do not offer email consultations. However, if you email the Office for Dr. Herskowitz or Dr. Wilson, and the email comprises questions concerning your treatment plan, you will be charged for the time necessary for the Practitioner to research, review, and respond to your email. Your credit card on file will be charged that or the following business day.

Your practitioner may decide that email communication is less efficient than an in-person or phone consultation. If your doctor determines that your email is too complex and requires an in-depth explanation, you will be asked to schedule a phone or in-person consultation with your doctor so that your question(s) may be adequately and appropriately addressed. The phone calls are billed at the regular, in-office rate with payment due via credit card at the end of each call.

I understand and agree to the terms of Anatara Medicine, Spirit Medical Group, and SFSCTC's payment and cancellation policies.

Signature: _____

Date: _____

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Notice of Information Practices

(Detailed Disclosure of Health Information)

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.

Understanding Your Health Record/Information

When you arrive at the Practice, a record of your care and treatment is initiated. Upon thorough examination and assessment, this record will typically contain your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Our Responsibilities

The Practice is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice

- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice.

How We May Use or Disclose Your Health Information

(1) Treatment. We will use your health information for treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from our facility.

(2) Reimbursement. We pledge our best efforts to provide you with the necessary forms and supportive information in a timely manner so as to optimize reimbursement to you. Any reimbursement from your insurance company should go directly to you. In this process, we will use your health information. For example, a bill may be sent to a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. As a reminder, since nearly all of our services are considered alternative or non-standard, the only items we provide superbills for, typically, are, with appropriate diagnosis codes, Dr. Herskowitz's consultations, and Vitamin C drips; we do not provide superbills for other services. If you have questions about this, please see the Office Manager prior to receiving any care.

(3) Health care operations. We will use your health information for regular health operations.
For example, members of the medical staff, the interdisciplinary team, or consultants may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

(4) Business associates. There are some services provided in our organization through contacts with business associates. Examples include our accountants, consultants and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

(5) Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them
at the phone number that they have provided us. e.g., on an answering machine.

(6) Communication with family. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

(7) Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

(8) Public health. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We reserve the right to charge for forms as requested or records copied and supplied.

(9) Law enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

(10) Reports. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Your Health Information Rights

Although your health record is the physical property of the Practice, the information in your health record belongs to you. You have the following rights:

You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Practice's general health care operations, and/or to a particular family member, other relative or close personal friend. We ask that such requests be made in writing on a form provided by our facility. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it. For more information about this right, see 45 Code of Federal Regulations (C.F.R.) 164.524.

If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by our facility to make such requests. For a request form, please contact our Practice Administrator. For more information about this right, see 45 C.F.R.164.526.

You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years). We ask that such requests be made in writing on a form provided by the Practice. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment or health care operations; disclosures made to your or your legal representative, or any other individual involved with your care; disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes.

You have the right to obtain a paper copy of our Notice of Information Practices upon request.

You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

For More Information or to Report a Problem

If you have questions and would like additional information, please contact the Practice's Administrator.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing on a form provided by the Practice. The complaint form may be obtained from the Practice Administrator, and when completed should be returned to the Administrator. You may also file a complaint with the secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint.

Our fees as related to Consultations:
We schedule consultations as requested, and those are scheduled with our practitioners with the following format: 1 hour consultation is 45 minutes of face-to-face time, and 15 minutes for treatment planning or changes. And consultations fees are charged according to the amount of time spent by the practitioner.

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Patient's HIPAA Consent

To the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Anatara Medicine and the San Francisco Stem Cell Treatment Center (SFSCTC) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that our clinic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Photo/Video Consent: The Practice may request to use photo, video or sound recordings of you for promotional purposes. By signing this form, you are giving permission to The Practice to take and use photographs, sound or video recordings of you. This is completely voluntary and up to you.

Email Consent: This office follows HIPAA guidelines and is dedicated to keeping your medical information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. We do not use an encrypted email portal.

I understand that this office will not be responsible for information loss, delay, or breaches in confidentiality including those due to technical factors beyond this office's control.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____

Name

_____ Date _____

Signature

1700 California Street, Suite 520
San Francisco, CA 94109
Phone: (415) 345-0099 | (800) 318-6006
Fax: (415) 345-0059