Habib Complementary and Integrative Medicine

Farangis M. Habib, M.D.

Pediatric Specialist in Complementary and Integrative Medicine

Notice and Consent as to Nature of Service

I understand that the care I receive from Dr. Habib may be non-traditional or nonconventional. Such services are commonly referred to as complementary or alternative medicine CACM or CAM), holistic care, or integrative medicine. This can include a variety of innovative medical treatments as well as acupuncture, nutritional and herbal consultation, and mind-body approaches to care. Many of these services may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, they may still be considered investigation or experimental. I am seeking care form Dr. Habib in order to benefit from her special training in integrative medicine and receive advice and treatment about such care.

Nutritional and Herbal Guidance*:* Consultations may include discussion of diet, dietary supplements, and herbal or botanical products. While herbs and botanical products are generally available over-the counter and considered safe based upon their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experiences for some medications, such as for high blood pressure or blood sugar. I will let Dr. Habib and other physicians know what herbs I am taking. And I agree to notify Dr. Habib if I experience any interactions or adverse experiences or reactions; if they are not serious, I will notify her to ask for her assistance and if serious, I agree to seek emergency care first before notifying Dr. Habib.

Recommendations could include fasting and other forms of detoxification. While this is generally safe, some people may experience a healing crisis, which may be a short period in which one's symptoms increase, or a period of a flu-like illness during which there could be some mild fever, chills, dizziness, loss of appetite, and so forth. Such an experience, while unpleasant, can signal that the body is effectively detoxifying or undergoing a healing effort.

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Phone: 703-573-2432 ⚕ Fax: 703-280-9350
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Mind/body Medicine: Mind/body medicine is an emerging medical view intended to improve patient well-being by improving lifestyle, capacity to function in a meaningful and effective way and reversing the impacts of stress. Because stress and emotional states may play an important role in my medical conditions, Dr. Habib may assist me in recognizing more successful approaches to lifestyle and mind/body approaches such as mediation, massage, or other stress management techniques.

Energy Medicine: Energy medicine is a controversial approach to healing that has a long traditional history across many cultures, and for which there is some evidence can have a healing benefit. It is a "hands off' approach in which the practitioner channels life energy for healing benefit, intended to affect the balance and flow of energy in a manner that might be thought of as similar to acupuncture, but without needles. It may be ineffective, or it is possible that it could temporarily aggravate symptoms. I understand that while these approaches can provide an important complement to my health care, I should ensure, by discussing my health needs with Dr. Habib and my primary care physicians, that appropriate mainstream care is provided, I understand that Dr. Habib will discuss potential therapies that she recommends, and I agree to accept the risks explained to me about these procedure by agreeing to understand these treatments.

I have read and understand the nature of the services provided by Dr. Habib. I represent that I am seeking treatment in order to further my own health and for no other reason. I agree to take a responsible role in improving my own health and discuss the advice and suggestions of Dr. Habib as presented in the treatment plan. I acknowledge that if I do not follow the treatment plan as provided, I may not receive the full benefit of the treatments proposed by Dr. Habib and I accept responsibility for less than satisfactory results. I am aware that I may withdraw this consent and discontinue following the recommendations at any time.

______________________________	______________________________
Signature of Patient or Legal Guardian	Witness
______________________________	______________________________
Patient's Printed Name	Date

Treatment Authorization: I authorize medical and health care treatment of ___________________my minor child by Dr. Habib, M.D.

Medical Records Release Authorization: I authorize Dr. Habib to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request.

I also authorize any physician or health care provider I have seen to release my medical records regarding my minor child, if applicable.

Privacy Statement: While Dr. Habib is not required to follow the privacy requirements under the Health Insurance Portability and Accountability Act CHIPAA), she does respect your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operations, or specifically authorized by you.

Notice as to Possible Non-Coverage of Services: I understand that because of the non-conventional nature of Dr. Habib services, insurance reimbursement may not be available. My insurance company may not pay for acupuncture services for example, and in some cases may not pay for office visits where the focus of the consultation is on wellness, herbal medicine, or other CMA services. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or kits sent to labs using innovative approaches to diagnostics may also not be reimbursed.

Financial/Insurance Responsibility: I understand that Dr. Habib does not participate in any insurance plans. I understand and agree that Dr. Habib does not take assignments, which means that payment will be required at each visit. I understand that I will receive a super bill showing the cost and nature of services and it will be my responsibility to submit these claims to my insurer. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Habib to take action to secure payment of an outstanding balanced owned.

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Claim Management: I understand that it is my responsibility to know my plan benefits. Dr Habib may offer some assistance, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect. Dr. Habib will respond to insurance requests for information but will not be obligated to act on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information.

Cancellation Fee: A cancellation fee of $50.00 will be assessed for missed appointments not canceled with more than 24 hours' notice. OR Full payment is required if appointments are not canceled with more than 24 hours' notice.

No Guarantees: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

Duration/Revocation of Authorization: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

Date: ___________________

______________________________ ______________________________

Patient/Guardian **Patient/Guardian Name Printed**

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