

North Star Naturopathic Medicine

The Medical Practice of Dr. Christina Caselli, ND – Mount Shasta, California

Welcome to North Star Naturopathic Medicine

We are pleased to have you join our clinic! We can be your primary care provider overseeing all your health concerns or work as a specialist in collaboration with your other providers. We want to hear about all the other providers you receive care from so we can optimize the care you receive from us. We will work with you in a holistic way by taking into consideration your physical, mental and emotional wellbeing. We can work with anyone living in California or Oregon via telehealth or in person at our Mt Shasta office.

First Visit

90 minutes. This visit consists primarily of information gathering. We will start to get to know you as an individual, learn about your past medical history and what your current medical needs are. This is done by having a detailed interview and physical exam. Please bring with you any recent blood work, imaging, medications and supplements so we can get the most out of this visit. Initial paperwork takes at least 10 minutes so allow for enough time to finish it.

Clinic Hours

Dr. Caselli sees patients in Mt Shasta on Tuesdays, Wednesdays, and some Thursdays in person or via Telehealth in Mt Shasta. Hours are subject to change and will be changed on the phone message and website as soon as possible.

Scheduling

Visits can be scheduled by calling 530-925-3221 or email us at info@NorthStarMedicine.com. If you receive a recording, we will get back to you as soon as possible. **Clinic e-mail is to be used for brief, NON-URGENT issues only. Call with all urgent questions.**

E-mail

Use of e-mail is appropriate for clarification of on-going treatment plan received within the last 30 days or to schedule a visit. E-mails should be brief, clear and concise. If your questions require more involved evaluation, we will request that you make an office visit. No diagnosis, medication or supplement changes, or treatment of a medical condition will be done by e-mail. E-mails will not be answered on weekends, holidays or when we are out of town. Every effort will be made to return your e-mail within 5 business days. E-mail is not 100% confidential due to the nature of the internet and you except the risks of a potential confidentiality breach when e-mailing us. However, all effort will be made to ensure confidentiality.

Telephone

If you have clarifying questions regarding your treatment or requests for prescription refills, you may contact the clinic and leave a message on the voicemail system. Every attempt will be made to return your call within 1 business day, usually at the end of the day. Refills can take up to 7 business days to complete, so plan accordingly.

Urgent Pager

If you have an urgent medical question, that cannot wait until the next business day call Dr. Caselli's urgent pager number at 530-918-8486. Your call will be returned ASAP. If we are out of town or out of service range, the call will be returned as soon as possible upon our return. There is a \$50 base charge for this service plus additional fees based on time spent on the phone once the call is initiated. **If you are experiencing a medical emergency requiring immediate care, call 911!**

Text

There are no texting services at this office.

Phone: 530-925-3221

Fax: 1-888-974-1834

Info@NorthStarMedicine.com

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Dispensary

We do not stock dispensary items at this time but reserve the right to do so in the future. We will give you a variety of options for obtaining supplements for your convenience. We do make a 15% margin on MFRP when you purchase supplements through Fullscript, our online dispensary. This margin covers costs of time spent managing supplement regimens. You receive a 10% discount from Fullscript if you choose to purchase through them, but you can decide to obtain supplements from any source of your choosing. If you choose to purchase alternate brands of products other than what is recommended, we cannot vouch for their safety or effectiveness.

We only recommend products that have enacted voluntary quality assurance and quality control using the proposed FDA cGMP standards. Many companies voluntarily comply with cGMP standards. However, the companies that don't implement cGMP guidelines may contain contaminants, fillers, or be absent of the listed contents. We cannot evaluate every product and will recommend specific companies that we know adhere to these guidelines. We always limit recommendations to a minimum due to cost and convenience concerns.

Billing & Insurance

Payment is due at time of service. Payment plans will be considered on an individual basis and may be terminated at any time. Naturopathic doctor visits are currently not covered by most insurance policies. We encourage you to contact your insurance provider, prior to your visit, to see if naturopathic care is covered by your policy. Some of our services may be covered depending on your insurance company and policy. Services that are typically covered by most private insurance includes pharmaceuticals, imaging, and laboratory tests ordered by naturopathic doctors. We do not directly bill insurance at this time. We can accept funds from HSA or Medical Flexible Spending Accounts. We can provide you with the necessary paperwork to submit to your insurance carrier in order to attempt reimbursement. There are no guarantees this will be effective.

Fees

Visits are scheduled based on the needs stated by the client at the time of scheduling. First office calls (FOC) are always scheduled for 90 minutes and cost \$300. Return office calls (ROC) can be scheduled for 15, 30, 45, 60 or 90 minutes. If new issues arise during a visit and time permits, the visit can be extended by client request. Once you have established care with us, your return office visit ranges from \$100-\$300 depending on how much time you need with us. Ask for our fee schedule for details. We offer an Economic Hardship Discount of 15% for individuals who are below the Federal US Poverty Guidelines. If you think you might qualify for this discount, ask us for details.

Cancellation Policy

Please cancel your appointment at least 24 hours before your scheduled visit or you will be charged \$50.

Returned Checks

There is a \$40 returned check fee to cover our bank costs.

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Naturopathic Informed Consent to Treat

This document provides important information regarding the services being provided and should be carefully reviewed. Please ask any questions you have regarding services before signing this document.

Consent: I hereby request and consent to the performance of naturopathic treatments and/or other naturopathic procedures, including various modes of physical therapy and diagnostic procedures, on me (or on the patient named below, for whom I am legally responsible) by Dr. Christina Caselli, ND, or a licensed Naturopathic Doctor in the state of California, who now or in the future may treat me while employed by, working or associated with or serving as a back-up for the Naturopathic Doctor named above, including those working at the clinic or office listed below or any other office or clinic whether signatories to this form or not. I understand that while Naturopathic Doctors in the state of California are considered primary care doctors, they do not have hospital admitting rights at this time and I will have to have established care with an MD or DO for those specific privileges.

Type of care: I have had an opportunity to discuss with the Naturopathic Doctor named above and/or with other office or clinic personnel the nature and purpose of naturopathic care and procedures.

I understand that this office utilizes many forms of diagnosis and therapy including but not limited to:

Physical exam: e.g. general; musculoskeletal; cardiovascular; gynecological; abdominal; respiratory; neurological; urological.

Medicinal use of nutrition: therapeutic nutrition; nutritional supplementation.

Botanical medicine: botanical substances may be prescribed as teas alcohol-based tinctures; capsules; tablets; creams; plasters; or suppositories.

Lifestyle counseling and hygiene: diet therapy; promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Psychological counseling

Hydrotherapies: e.g., hydrocolator; contrast treatments; wet sheet wrap; constitutional hydrotherapy.

Soft tissue manipulation: massage, neuro-muscular technique; Muscle Release Techniques.

Contraception and other hormone replacement therapies for men and women

Intravenous, intramuscular and subcutaneous injections: nutritional supplementation; therapeutic nutrition; pain management; joint care.

Oral chelation therapy

Pharmaceutical medication management

No Guarantee: I understand that results are not guaranteed.

Recital of Risks: I understand and am informed that, in the practice of medicine, there is always some risk to treatment. Within the general health care setting, the possible outcomes of these practices range from minor to fatal.

I understand that some herbs and supplements may be inappropriate during pregnancy, and I will notify the doctor if I am or become pregnant.

I will inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomach ache, vomiting), allergic reactions (hives, rashes, tingling of the tongue, difficulty breathing, headache), or any unanticipated or unpleasant effects associated with the herbs, supplements or other treatment prescribed by the doctor. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have read, understood, and been offered a copy of the Health Information Privacy Act (HIPAA).

Signature of Patient/Guardian: _____ Relationship to Patient: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways North Star Naturopathic Medicine may collect, store, use, and disclose your protected health information, and your rights concerning your protected health information. “Protected Health Information” is information about you that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for that care.

Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining your authorization.

- **Payment.** We may use and disclose your protected health information in order to be paid for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- **Treatment.** We may use and disclose your protected health information to assist your other health care providers in your diagnosis and treatment.
- **Health Care Operations.** We may use and disclose your protected health information in order to perform various operational activities.
- **Enrolled Dependents and Family Members.** We will mail “explanation of benefits” forms and other mailings containing protected health information to the address we have on record for you.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.
- **Victims of Abuse, Neglect, or Domestic Violence.** We may disclose your protected health information to government agencies about abuse, neglect, or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners or Funeral Directors.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

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- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures With an Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding your Protected Health Information

You may have certain rights regarding protected health information that Dr. Christina Caselli, ND maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **Right to Amend Your Protected Health Information.** If you feel that your protected health information maintained by Dr. Caselli is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask us to amend information that was not created by Dr. Caselli or you ask us to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. **We may not agree to your request.** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

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Health Information Security

Dr. Christina Caselli, ND requires its employees to follow its security policies and procedures that limit access to health information about patients to those employees who need it to perform their job responsibilities. In addition, Dr. Christina Caselli, ND maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

This is not a contract between you and North Star Naturopathic Medicine. This is only a notice of the federal laws regarding the privacy of your health information. By signing this form you are only acknowledging that you have been provided this information.

Signature of Patient/Guardian: _____ Relationship to Patient: _____ Date: _____