CLIENT BILL OF RIGHTS

Health with Homeopathy

I am pleased to provide you with this Client Bill of Rights in accordance with Minnesota laws governing complementary and alternative health care practices.

1. Degrees, training, and experience:

I am a graduate of Northwestern Academy of < ca YcdUh\ mifU Zci f mYUf A UghYfg Yj Y dfc[fUa]b 7 Ugg]WU < ca YcdUh\ mt UbX \ Uj Y bUh]cbU WYfh]Z]WUh]cb! 77< . I have a BS degree in Kinesiology from the University of Minnesota. I have over &$ years experience in clinical and surgical settings as a Certified Surgical Technologist and Orthopedic Physician's Assistant-Certified.

In accordance with Minnesota law, I am providing you with the following notice:

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

2. Right to file a complaint. I am the supervisor of my private practice. If you have concerns, you may file a complaint with me and/or with the following office:

Health Occupations Program
Minnesota Department of Health
85 East 7 Place, Suite 300
Post Office Box 64882
St. Paul, MN 55164-0882 651-282-3823 Fax 651-282-3839

3. Fees for unit of service. Please see fee statement. Fees are payable in full at the time of service by cash, check, credit card. I do not accept Medicare, Medical Assistance, or General Assistance Medical Care.

4. Change in services or charges. You have a right to reasonable notice of changes in services or charges and I will provide prior notice of any changes.

5. Summary of Practices/Services. Please review the attached document that provides a description of classical homeopathy. If you have any questions, please ask.

6. Information about assessment and recommended service. You have a right to complete and current information concerning my assessment and recommended service, including expected duration of the service to be provided. If you have any questions, please ask.

7. Courteous treatment. You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.

8. Confidentiality of client information. Your records and other information about you are confidential. This information will not be released unless you authorize release in writing or unless release is required by law.

9. Access to client records. You are allowed access to records and other written information in accordance with Minnesota Statutes, section 144.335.

10. Other available services. If you are interested in other available services in the community, you may wish to consult the Minnesota Homeopathic Association.

11. Change practitioners. You have the right to choose freely among available practitioners and to change practitioners after services have begun within the limits of health insurance, medical assistance, or other health programs.

12. Coordinated transfer. If you change practitioners, you have the right to my assistance in coordinating this transfer to another practitioner.

13. Refusing services. You have the right to refuse services or treatment, unless otherwise provided by law.

14. No retaliation. You may assert your rights without retaliation.

I hereby acknowledge receipt of the Client Bill of Rights and the attached documents incorporated therein, and I have had a full opportunity to ask any questions I have about this document and my rights as a client. I understand my rights as a client.

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Client Signature **Date**

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Parent or Guardian Signature **Date**

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Witness **Date**