LEAPS, LLC
Leang Eap, N.D. • 4724 Park Road, Ste B • Charlotte, NC 28209• Tel: 704-527-8089

NEW CLIENT REGISTRATION

Client Name: _____Referred by: _____
Date of Birth: _____ Age: _____Sex: _____ Marital Status: _____ SSN: _____
Home/ Mailing Address: _____
Home Phone: _____Work Phone: _____ Cell Phone: _____
Email: _____ Occupation: _____
Employer: _____Employer Address: _____

Spouse's Name: _____Work Phone: _____Cell Phone: _____
Spouse's Employer Name & Address: _____
_____

In case of an emergency, contact: _____ Relationship: _____ Phone: _____
Address: _____

DISCLAIMER and DISCLOSURE STATEMENT

I recognize that Leang Eap, ND is a Doctor of Naturopathic Medicine and is not a licensed medical physician. While naturopathic physicians are licensed in other states, no such licensing provision currently exists in North Carolina. LEAPS LLC and Leang Eap, N.D. are not functioning in the capacity of a medical physician or a medical practice. Dr. Eap does not profess to be a medical physician, and she does not diagnose or treat diseases. She functions as a wellness provider using a holistic approach where the spiritual, mental, emotional and physical aspects of a person are recognized to be interrelated for optimum health. She practices healing arts that rely on the body's inherent healing capacity and utilize a wide range of therapeutic systems to work with the body to assist healing.

I also recognize that nutritional, homeopathic, herbal supplements and other therapeutic systems (aromatherapy, hydrotherapy, etc.) may be recommended and/or given to me as part of my treatment. Such substances and therapies may cause adverse reactions in some people. I release and hold harmless Leang Eap, N.D., LEAPS LLC and QI SOLUTIONS LLC and their respective employees in the event such adverse effects may occur.

I understand that Leang Eap, ND and staff do not guarantee improvement of my condition. I also understand that the services provided by Leang Eap, ND and staff are complementary to allopathic medicine and do not replace the need for diagnosis and treatment by a licensed medical physician. I voluntarily seek these services for myself or my legal ward and assume full responsibility for this decision.

☐ I am currently under the care of a medical doctor for conventional medical diagnoses. (If not, please execute waiver of liability.)

Signature: _____ Date: _____

STATEMENT OF POLICIES

Appointments: Appointments must be made in advance. If, for any reason, you are unable to keep an appointment, please give us 24 hours cancellation notice. Please leave a message with our answering service if you are not able to reach us in person. This makes it possible for us to utilize the time set aside for you and also to reschedule your visit. In accordance with customary practice, there is a $40.00 charge for failure to cancel an appointment without notice of at least 24 hours.

Health Insurance Policy: This office does not fill or mail insurance forms. You are responsible for obtaining reimbursement from your insurance company. You should also know that most of the therapies practiced in this office are non-allopathic and most insurance companies may not honor claims submitted for our services.

Payment and Billing: Payment for services rendered is expected at the time of your visit unless prior arrangements have been made. Charges for supplements and remedies must be paid at the time they are ordered and/or given. Payment is accepted in the form of cash, money orders and traveler checks. There is a $25.00 charge for any returned check. Generally we do not bill. This minimizes office expenditures and thus benefits you as well. If your account is overdue, you will be charged a $10.00 billing fee each time we find it necessary to bill you. We reserve the right to refuse further services to any client with a past-due balance until the balance is paid.

For our records: Please sign below to indicate that you have read and understand the above policy agreement and admit full responsibility in compliance with the terms of this agreement.

Signature: _____ Date: _____

LEAPS, LLC
4724 Park Rd., Ste B
Charlotte, NC 28209
704-527-8089

CONSENT TO CONSULTATION

Please read, carefully, the following:

1. The consultants of LEAPS, LLC are not primary care physicians.
2. The consultants of LEAPS, LLC are not board certified oncologists, immunologists, endocrinologists, gynecologists, cardiologists, psychiatrists or other medical specialists.
3. For people as well as family members or close personal friends of those people who have been diagnosed with any of the following conditions (Cancer, Diabetes, Asthma, Coronary Heart Disease, Diseases of the Thyroid Gland, Gynecological Services, AIDS/HIV, Stroke, Parkinson's disease, Epilepsy, Multiple Sclerosis, Alzheimer, Sexually Transmitted Diseases, Bipolar Disorder, Clinical Depression, Schizophrenia, Fertility conditions, Obesity, Weight conditions and ADD/ADHD), LEAPS, LLC provides consultative services under the following circumstances, that :
    a. the consultee(s) understand(s) that the consultants of LEAPS, LLC (herein referred to as Leang Eap, N.D.) cannot manage the overall care of the person with any of the conditions listed above for whom the consultation is occurring;
    b. the consultee(s) understands(s) that the treatment suggestions provided by Leang Eap, N.D. are not all accepted by the United States FDA and therefore should not taken as such;
    c. the consultee(s) understand(s) that the treatment suggestions provided by Leang Eap, N.D. are not intended to replace those treatments prescribed by the physician managing the case, overall;
    d. the consultee(s) understands that the consultants of LEAPS, LLC may suggest changes to the therapeutic plan for the person with any of the conditions listed above for whom the consultation is occurring, within the scope of their licensure;
    e. the consultee(s) understand that it is important to make the managing physician aware of any additions or changes to the treatment plan for the person with any of the conditions listed above for whom the consultation is occurring; and that
    f. the consultee(s) understand(s) that Leang Eap, N.D. is not a provider for Medicare, Medicaid or any other insurance carrier and therefore the services rendered by Leang Eap, N.D. are not covered by any insurance plan.

By signing below, I, _____, have read and understood the above criteria and give my full consent to consultation from Leang Eap, N.D.

Signature Date

Printed Name

LEAPS, LLC
4724 Park Rd., Ste B
Charlotte, NC 28209
Tel: 704-527-8089

Date: _____

Informed Consent and Request for Naturopathic Medicine Treatment

Patient Name: _____

I, as a patient or legal guardian of the patient named above, have the right to be informed about conditions and recommend care. 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 having had the opportunity to discuss the potential benefits, risks, and hazards involved.

I hereby request and consent (or for the patient named above for whom I am legally responsible) to examination and treatment with Naturopathic Medicine by Leang Eap, N.D. and/or other licensed doctors of Naturopathic Medicine or those working or training at the office, who now or in the future may treat me while employed by, working, associated or, training with or serving as backup for her, hereafter called allied health care provider. I can request students and preceptors not are included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Leang Eap, N.D. and/or the allied health care provider concerning the following:

1. my suspected diagnosis and condition
2. the nature, purpose and potentials benefits of the proposed care
3. the inherent risks, complication, potential hazards, or side effects of treatment or procedure
4. the probability or likelihood of success
5. reasonable available alternatives to the proposed treatment and procedure
6. the possible consequences if treatment or advice is not followed and/or nothing is done

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general, musculoskeletal, orthopedic, and neurological assessments)
- Common diagnostic procedures (venipuncture, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (massage, neuro-muscular technique, muscle energy stretching, cranio-sacral therapy, osseous manipulations of the extremities and spine.
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials). Substances may be given in the forms of teas, pills, creams, powders, tinctures, suppositories, which may contain alcohol, topical creams, pastes, plaster, washes or other forms.
- Homeopathic remedies (often highly diluted quantities of naturals occurring substances)
- Hydrotherapy (use of hot and cold water, colon therapy, cryotherapy)
- Counseling (including but not limited to biofeedback, hypnosis, and visualization for improved lifestyles strategies and wellness).
- Over the counter and prescription medications (including only medications approved by the Department of Health).

I understand and I am informed that in the practice of Naturopathic Medicine that there are some risks and benefits with evaluation and treatment including, but not limited to the following:

Potential risks: pain, discomfort, blistering, minor bruising, discoloration, infections, burns, loss of consciousness, and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; an aggravation of pre-existing symptoms.

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

Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could be a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. The treatment intended to induce labor requires a letter from a primary care provider authorized or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and cancer. For your safety, it is important to alert the provider of these conditions.

_____ I understand that Dr. Eap is not licensed to prescribe any controlled substances.
_____ I understand that Dr. Eap will not manage patient's prescriptive medication need. The patient needs to discuss the management of all prescribed medications with a medical doctor.
_____ I understand the US Food and Drug Administration has not approved nutritional, herbal, and homeopathic substances, flower essences and aromatherapy; however they have been widely used in Europe, Asia and USA for years.
_____ I understand that Dr. Eap is not a psychologist or psychiatrist. Counseling services are for the improved lifestyles strategies and wellness.

I do not expect Dr. Eap and/or staff to be able to anticipate and explain all 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 provider to explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. 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 the above and given 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 am seeking treatment.

Participation of student/preceptor: _____ accepted _____ declined

_____ _____
Patient's Signature Signature of Patient's Legal Guardian

_____ _____
Patient's Printed Name Patient's Legal Guardian Printed Name

Provider's Signature: _____

LEAPS, LLC
4724 Park Rd., Suite B
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NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of LEAPS. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:
- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

LEAPS LLC Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Dr. Eap. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

HIPAA Privacy Standards
Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Leang Eap, N.D.
LEAPS, LLC
4724 Park Rd., Ste B
Charlotte, NC 28209
Tel: 704-527-8089

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is:

Leang Eap, N.D.
4724 Park Rd., Ste B
Charlotte, NC 28209
Tel: 704-527-8089

Effective Date
This notice is effective on or after April 14th, 2003

RELEASE OF LIABILITY AGREEMENT
AGREEMENT NOT TO SUE
INDEMNITY AGREEMENT

YOU ARE GIVING UP IMPORTANT LEGAL RIGHTS
READ THIS AGREEMENT CAREFULLY BEFORE SIGNING

Because I have disclosed to LEAPS, LLC and Dr. Leang Eap, N.D. that at this time I do not have a primary care physician or medical doctor with whom I pursue traditional medical diagnoses. As such, I am voluntarily executing this Release and Indemnification Agreement since I am requesting that I receive treatment and consulting from Dr. Leang Eap, N.D. and LEAPS, LLC despite her requirement that all individuals with whom she works have a primary care physician or medical doctor.

MY PROMISE NOT TO SUE
I agree that I will not sue, or otherwise make any claim against the LEAPS LLC for injury, death or damage to me in the course of my participation or care received from Dr. Leang Eap, N.D.

MY RELEASE OF LIABILITY
I also agree to release and discharge LEAPS, LLC and Dr. Leang Eap, N.D. from all actions, claims, or demands, both for myself and or my heirs or personal representatives, for injury, death or damage to me in the course of my participation or care received from Dr. Leang Eap, N.D., in any way resulting from the negligence or other acts, however caused, of LEAPS, LLC and Dr. Leang Eap, N.D.

MY PROMISE TO INDEMNIFY
I agree to pay all costs and expenses, including attorneys' fees and court costs, that LEAPS, LLC and Dr. Leang Eap, N.D. may incur as a consequence of any legal action arising out of (1) injury, death, or damage to me.

All of the terms of this Agreement are binding upon me, my relatives, heirs and personal representatives. The terms of this agreement shall also be binding upon any persons or members of my family, including minors who may accompany me. I am over the age of eighteen (18) years of age, or my legal guardian has also read, initialed and signed this Agreement below my signature.

I have carefully read this agreement and fully understand its contents. I am aware that this is a binding legal contract between myself and LEAPS LLC and/or its agents, and I sign it of my own free will.

DATE: _____ SIGNATURE:_____

NAME (PRINTED): _____

SIGNATURE OF LEGAL GUARDIAN (Required if the participant is under the age of 18 years)

I am the parent and/or legal guardian of the above participant. I have read the above agreement and fully understand its contents. I am aware that the above agreement is a binding legal contract between myself, the above participant, and LEAPS LLC and I agree to be bound and held by the terms of the above agreement.

DATE: _____ SIGNATURE:_____

NAME (PRINTED) of Legal Guardian: _____

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CONSENT TO CONSULTATION (CANCER)

Please read, carefully, the following:

1. The consultants of LEAPS, LLC are not primary care physicians.

2. The consultants of LEAPS, LLC are not board certified oncologist or immunologists.

3. LEAPS, LLC provides consultative services to people who have been diagnosed with cancer, as well as to the family members or close personal friends of those people who have been diagnosed with cancer under the following circumstances, that :

    a. the consultee(s) understand(s) that the consultants of LEAPS, LLC (herein referred to as Leang Eap, N.D.) cannot manage the overall care of the person with cancer for whom the consultation is occurring;

    b. the consultee(s) understands(s) that the treatment suggestions provided by Leang Eap, N.D. are not all accepted by the United States FDA and therefore should not taken as such;

    c. the consultee(s) understand(s) that the treatment suggestions provided by Leang Eap, N.D. are not intended to replace those treatments prescribed by the physician managing the case, overall;

    d. the consultee(s) understands that the consultants of LEAPS, LLC may suggest changes to the therapeutic plan for the person with cancer for whom the consultation is occurring, within the scope of their licensure;

    e. the consultee(s) understand that it is important to make the managing physician aware of any additions or changes to the treatment plan for the person with cancer for whom the consultation is occurring; and that

    f. the consultee(s) understand(s) that Leang Eap, N.D. is not a provider for Medicare, Medicaid or any other insurance carrier and therefore the services rendered by Leang Eap, N.D. are not covered by any insurance plan.

By signing below, I, _____, have read and understood the above criteria and give my full consent to consultation from Leang Eap, N.D.

Signature Date

Printed Name