

CLIENT BILL OF RIGHTS

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651-641-1844**

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 of Practitioner:

I have been practicing homeopathy since 1997. I completed a three year training program at the Northwestern Academy of Homeopathy and an additional three-year program at the Dynamis School for Advanced Homeopathic Studies. I am registered with the North American Registered Society of Homeopaths and have a certificate to practice Classical Homeopathy from the Council for Homeopathic Certification.

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. Supervisor. I am the Supervisor of this private practice. My name and address are listed above. You have a right to file a complaint with me, by writing a letter with details of the nature of the complaint.

3. Right to file a complaint. If you have any concerns, you may file a complaint with the following office:

Office of Unlicensed Complementary and Alternative Health Care Practice
Minnesota Department of Health Occupations Program
121 East Seventh Place, Suite 400
P.O. Box 64975
St. Paul MN 55164-0975
651-282-6319 or 1-800-657-3957

4. Fees for unit of service. Please see my [current fee statement](#). Fees are payable at the time of service by check or cash only. I do not accept Medicare, Medical Assistance, or General Assistance Medical Care. I do not accept partial payment or waive payment.

5. 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.

6. Summary of Practices/Services. Please review the [detailed description of classical homeopathy](#). If you have any questions, please ask.

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

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

9. 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.

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

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

12. 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.

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

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

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

I hereby acknowledge receipt of the Client Bill of Rights and the two referenced documents incorporated therein (fee statement, detailed description of classical homeopathy), 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.

Client Signature

Date

Parent or Guardian Signature

Date