CLIENT BILL OF RIGHTS

Hoglund Homeopathy, LLC

970 Raymond Ave #202
Saint Paul, MN 55114

We are 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:

Jennie Hoglund is a graduate of Northwestern Academy of Homeopathy, a four-year training program, including a two-year clinical rotation.

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:

Jennie Hoglund, contact:

Office of Unlicensed Complementary and Alternative Health Care Practice
Minnesota Department of Health Occupations Program
85 East 7th Place, Suite 300, PO Box 64882
St. Paul MN 55164-0882
651-282-3823, 1-800-657-3957, Fax 651-282-3839

4. Fees for unit of service. Fees are payable at the time of service by cash, check, or credit card. (See attachment One, FEE SCHEDULE). We do not accept Medicare, Medical Assistance, or General Assistance Medical Care. We do not accept partial payment or waive payment. (See Attachment Two, PAYMENT POLICY).

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

6. Description of Services. Please see the article "What is Homeopathy," provided to you in your clinic information packet, and available in our reception room.

7. Information about assessment and recommended service. You have a right to complete and current information concerning any 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 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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HH Witness **Date**