ADVANCED ALLERGY RELIEF OF CONNECTICUT ~ Anne Mitchell, N.D
2 Broadway, North Haven, CT 06473 203-239-3400 / beallergyfree@gmail.com

Office Policy

Thank you for choosing naturopathic medicine and this office for your health care needs. We hope your time with us is all you wish it to be. We encourage comments, questions, and suggestions. Your health and well being are our prime considerations.

- **Office Hours**
  Office hours are Tuesday, Wednesday, Thursday and Friday.

- **Cancellation Policy**
  Your appointment time is reserved for you so please notify us if you can't come.
  We try to remind you by phone before your appointment. If you do not want us to call or leave a message for you please let us know.
  We ask for a minimum of 48 hours notice for cancellations so we can give your time to someone else. You may be charged for a missed appointment.

- **Telephone Calls**
  The staff is knowledgeable and available to answer most of your questions. If we are busy with patients, the telephone will be answered by an automated system. Leave a message and your call will be returned as soon as possible. If you're ill or in pain, please say so at the time of your call so we can determine if you need to be seen immediately.

- **HIPAA**
  This is a very small medical office. Your health care information is confidential and access is limited. We use your health care information about you for diagnosis and treatment, to consult with other health care practitioners when necessary and with your permission, to obtain payment for treatment, for administrative services, and to evaluate the quality of care you receive. We will not disclose health information for other reasons without your signed permission unless it is required by law. You have the right to examine your records and to have copies for a reasonable fee. You may request a change in your records if you believe they are incomplete or incorrect. If you are concerned we have violated your privacy rights you may complain to us or directly to the US Department of Health and Human Services.

  We are required by law to protect the privacy of your information and to provide you with this information. More complete rules and regulations are available on request.

I understand my rights under the Health Insurance Portability and Accountability Act of 1996.

Patient Signature _____Date _____