PATIENT INFORMATION

Lymphatic Health Center
517 Alcove Rd, Ste 101 Mooresville, NC 28117
P: 704-664-7303

PATIENT:

NAME_____DATE OF BIRTH_____

ADDRESS_____CITY_____STATE____ZIP_____

HOME PHONE_____CEL PHONE_____

EMAIL_____

- OK TO EMAIL? YES_____ NO_____
- PHOTO CONSENT? YES_____ NO_____

EMERGENCY CONTACT:

NAME_____PHONE#_____

RELATIONSHIP_____

CREDIT CARD INFORMATION:

TYPE OF CARD:_____

CARD #_____CCV#_____

EXPIRATION DATE:_____ZIP CODE:_____

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FINANCIAL AGREEMENT - Lymphatic Health Center

BILLING:

We will keep your credit card on file- only for use with No Show or Late Cancellations (less than 24 hours).

_____ (Please initial)

CANCELLATION POLICY:

We reserve your appointment time exclusively for you to best meet your schedule and ours. Therefore, we require a 24-hour notice for all cancellations. **Failure to provide a 24-hour notice of cancellation will result in a $25 fee. There is a $40 no-show fee.** These charges will be immediately charged to the credit card on file. *In the event of two no-shows or frequent cancellations, the therapist has the right to terminate all future sessions. NO EXCEPTIONS.*

_____ (Please initial)

I have read and understand this letter and agree to the terms stated above.

Signature: _____ Date: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS -Lymphatic Health Center

I consent to the use or disclosure of my protected health information by LYMPHATIC HEALTH CENTER (LHC) for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of LHC. I understand that treatment of me by my therapist may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or other healthcare operations of the facility. LHC is not required to agree to the restrictions that I may request. However, if LHC agrees to a restriction that I request, the restriction is binding on LHC and my therapist.

I have the right to revoke this consent, in writing, at any time, except to the extent that my therapist and LHC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review LHC'S Notice of Privacy Practices prior to signing this document. The LHC Notice of Privacy Practices has been made available to me for review. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of LHC. The Notice of Privacy Practices for LHC is provided to each new patient and is also available in the waiting room area. This Notice of Privacy Practices also describes my rights and LHC'S duties with respect to my protected health care information.

LHC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient:_____ Date:_____

(or Personal Representative) Name: _____