akane institute
FEEL BETTER Live Your Life!
ALLERGY ASTHMA SLEEP MEDICINE

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BEHAVIORAL MEDICINE
Child • Adolescent • Adult Psychiatry

CONSENT FORM: MEDICAL TREATMENT/PRIVACY NOTICE

CONSENT FOR TREATMENT: The undersigned is under the care of a provider designated by AKANE Institute of Allergy, Asthma & Sleep Medicine/AKANE Institute of Behavioral Medicine (AKANE Institute) and hereby consents to and authorizes AKANE Institute to provide the necessary medical treatments, diagnostic procedures, drugs and supplies to the patient as ordered or requested by the provider. I acknowledge that no guarantee or assurance has been made as to the results of these services/products provided.

CONSENT FOR PHOTOGRAPHY/VIDEO: I Consent to the taking of pictures/videos of my medical or surgical condition or treatment, and the use of the pictures/videos for the purpose of my diagnosis/ treatment or for the education/ training programs conducted by AKANE Institute.

PATIENT'S RIGHTS AND RESPONSIBILITIES: I acknowledge that AKANE Institute has made available to me information regarding my rights and responsibilities as a patient. I am aware that an AKANE Institute representative is available to me if I have additional questions or otherwise wish to speak with one.

MEDICAL RECORD RELEASE AUTHORIZATION: I acknowledge that the AKANE Institute Privacy Notice has been made available to me. I understand that AKANE Institute may disclose information about me related to my treatment for purposes of continuous treatment, payment and health care operations to entities like other health care providers(your primary care physician and other referring doctors), insurance health plans, government agencies, etc. I further acknowledge that this information may be transmitted electronically by fax/internet/email. I understand that appointment reminders, lab and test results and other pertinent information related to my care may be left on my telephone answering machine if I cannot be reached or transmitted via email. I am fully aware that cell phone and email may not be secure and private. I agree to hold harmless AKANE Institute, its officers, directors and employees from any and all liability, loss, claims, or damages related to the release of such information.

ASSIGNMENT OF BENEFITS: I assign and authorize payment directly to AKANE Institute. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents any information needed to determine these benefits.

FINANCIAL TERMS: I understand that AKANE Institute is performing a courtesy for me by billing my insurance company and it is ultimately my responsibility to know my benefits and coverage and pay for services rendered. I will be responsible for any applicable deductibles and co-pays at the time of service. **I understand that in the event of failure to give a full 24 hour notice of cancellation for scheduled appointments or for missing an appointment, a $50 charge per cancelled office visit or $250.00 charge per cancelled sleep study will be assessed to my account. Payment for services provided is due within 30 days. All charges not paid in full by insurance and/or patient after 60 days will be sent to collections unless other payment arrangements have been made. For accounts sent to collections, an automatic 50% increase in the total will be assessed to cover collection charges.**

I, the undersigned, certify that I have read, understand, and agree to the provisions contained within the consent form and related documents mentioned above. The issues addressed on this form have been fully explained to me. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. This consent is valid indefinitely until revoked by me in writing.

_____ _____

(Patient's signature or signature of person consenting on behalf of patient) (Date)

_____

(Printed Name)

_____

(Relationship to patient, if applicable)

_____ _____

(Witness to patient's signature)/ AKANE Institute (Date)

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