Welcome to Inner Wellness of Central Illinois

Patient Information

Today's Date_____ Clinician _____

Personal Information

Client's legal name _____ Date of birth _____

Home address _____
Street City State Zip

Email address _____

Phone number _____ Text: yes or no _____

Gender _____ Marital Status_____ Work Status _____

Primary Insurance information

Primary Insurance company _____

Subscriber's name _____ Date of birth _____

Subscriber's insurance identification number _____

Relationship to client _____

If you have secondary insurance, please include the information on the back of this form

Referral Source

Did someone refer you to our practice? yes or no If so, who? _____

Would it be ok if we send the referral source a thank you note? yes or no

If the client is a minor, please print the name of the parent or guardian on minor's behalf

Print Full Name _____

Relationship to client _____

Missed appointments and no shows: Initials: _____

I am financially responsible for my attendance at all scheduled appointments, unless the appointment is canceled with at least 24 hours' notice. A minimum charge of $50.00 will be applied to my account for a cancellation and a $75.00 charge for a no show.

Copays and Deductibles:

I am responsible to call my insurance company to inquire about my copay responsibilities as well as my deductible.

Insurance Billing

I authorize Inner Wellness to release any medical information to my insurance company which may be deemed necessary to process an insurance claim. I agree to notify Inner Wellness whenever I have changes in my insurance coverage.

Account Responsibility

I am responsible for payment to Inner Wellness for all services rendered which is due at the time of service. If I default on any payment and am sent at least three statements, I acknowledge that my account will be turned over to a third party collection agency.

Clinical Staff Release

I understand that, as part of professional clinical consultation, my situation may be reviewed using general clinical information, and that my therapist will obtain a release of information from me prior to discussing details of my situation.

Informed Consent and Notice of Privacy Policies

I am consenting to have copies made of my driver's license, insurance card, and credit card to be kept on file at Inner Wellness. I am consenting to treatment and have received and understood the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPPA). My signature below indicates that I have been provided a copy of, and that I fully understand and agree to, all of the terms and conditions of the Inner Wellness Policies.

Client's signature _____ Today's date _____

Parent or Guardian's signature _____ Today's date _____

Conditions of Care

Thank you for choosing Inner Wellness of Central Illinois (herein referred to as The Company). This Consent for Care explains your responsibilities and provides your consent for us to provide treatment. I understand this includes and is not limited to diagnostic procedures, screening procedures, and treatment.

Consent to Treat

- I consent to diagnosis, medical care, and treatment that has been or may be ordered by a licensed care professional.
- I understand that all licensed healthcare professionals are responsible and liable for their own acts, orders, and omissions.
- I understand that no results of a particular examination or treatment can be guaranteed and there are risks of medical care which may include injury or death.

Telehealth

Necessary treatment may be provided via telehealth related technology or equipment. I have the right to refuse treatment via telehealth technology or equipment without affecting my future care or treatment.

Results of Treatment

I understand that care, tests, and treatments may have risks. These risks can result in injury or even death. I understand that no guarantees have been made to me as to the results of diagnosis, treatments, tests or examinations.

Drug and Alcohol Tests

I understand that drug and alcohol testing might be needed to find out what is wrong and to treat me.

Notice of Independent Practitioners

- I acknowledge and understand that there will be providers who are not employees or agents of the Company, but instead are independent practitioners or contractors.
- I understand that each of these providers exercises his or her own, independent judgment and is solely responsible for the care, treatment, and services that he or she orders, requests, directs or provides.

Release of Health Records for Payment

- In order to know what payments are to be made to the Company for my care, I agree to let the company share information about my care and treatment with health insurance companies, health plans, other health programs that process and pay for the care and treatment given, or other companies that agree to do work for those companies, and/or workers' compensation insurance companies and/or employers, if it is a workers' compensation case.

- This release is valid until all bills are paid.

Insurance, Health Plan, or Program Rules

- I understand that I need to follow all the rules of any insurance company or program that pays for my medical bills. Rules include, but are not limited to, getting a second opinion form another healthcare provider or calling the insurance company before treatments.
- If I do not follow the rules of the insurance company or program, they may not pay for my health care.

Payment for Services

1. I understand that I am responsible for all the costs associated with my care.
2. I understand by signing this Consent that the providers agree to bill my health plan, other insurance, Medicare, Medicaid, or TRICARE ("insurance") on my behalf and I assign my insurance benefits to the providers.
3. In order for the providers to bill my insurance, I agree to provide my insurance information to the Company and they may share the information with my independent providers.
4. If the providers have a contract with my insurance and the care is "medically necessary", I understand that I am responsible for any co-insurance, deductibles and co-pays for the care I receive.
5. If insurance does not cover my care, I am responsible for the entire cost of the care I received.
6. If my insurance doesn't pay, you have my permission to appeal the denial or file a grievance for me. I will assist you with this appeal or grievance and will let you know if the insurance company notifies me of the result of the appeal or grievance.
7. For the healthcare services given to me, I agree payment can go directly to the Company. This includes all payments to be paid for my healthcare and charges for healthcare providers' services billed by the Company. Payments may come from these sources but are not limited to primary and secondary health insurance, accident insurance, disability or loss-of-time insurance, Medicare, Medicaid and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and/or workers' compensation or work-related disease claims.

Fair Patient Billing Act.

- I understand that I may receive separate bills from the providers for services provided to me.
- I understand that all providers may not participate in the same insurance plans and networks. If a provider does not participate in my insurance plan, those services may be "out of network." I understand that I may have to pay more for "out of network" services. I am responsible for contacting my insurance company to find out whether the provider participates in my insurance plan or network.
- If I have questions about my insurance coverage or available benefits, I should contact my insurance plan or my employer. I understand that the providers cannot guarantee my care will be covered by insurance.

Failure to Pay

- I agree to pay on time.
- If I fail to pay the bills for my care, I agree that I will pay the costs that are incurred in pursuing payment from me, including collection fees, court fees, attorney's fees and other costs of collection.

Use of My Information.

You can use my phone numbers, mailing address and email address to contact me about my bill and amounts owed. It is okay for you to leave me a message about my account or my care using my phone number or email address I gave you, including pre-recorded messages or calls made using an auto-dialer.

Company Rules

- I agree to follow all rules.
- I understand and agree that if the Company at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my possession the Company may ask me to remove the weapon from the premises

Consent to Email and/or Text Usage for Appointment Reminders and Other Healthcare Communications

- Patients in our Company may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general health reminders/information.

- Standard text messaging rates may apply.

Notice of Non-Discrimination
This Company does not discriminate against any person on the basis of race, color, national origin, disability, sexual orientation, or age in admission, treatment, or participation in its programs, services, activities, or employment.

Consent
- I have read this consent for treatment, release of information to insurance, independent provider status, and financial responsibility; and all my questions have been answered to my satisfaction.
- I agree that the information I gave you about myself is correct, including my name, street address, city state, zip code, phone numbers, email, insurance information, medical history and all other information.

Signature of Consent

Patient name

_____

Patient/Parent/Legal Representative Signature Date

_____ _____

Witness Signature Date

_____ _____