FOUNDATIONS
Holistic Therapy

Consent to Treat Form

I _____ (patient name) give permission for Foundations Holistic Therapy to give me medical treatment.

I allow Foundations Holistic Therapy to file for insurance benefits to pay for the care that I receive.

I understand that:

- Foundations Holistic Therapy will have to send my medical record information to my insurance company.
- I must pay for my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any treatment.
- I have the right to discuss all medical treatments with my clinician/therapist.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (under 18) Date

_____ _____

Print Name Date

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Patient Information

Patient's name_____
Last First Middle Initial

Home Address_____ City, State & Zip_____

Phone: Home_____ Work_____ Cell_____
Where would you prefer we call you?_____

Marital Status (circle) : married single divorced widowed

Email address_____

Occupation_____ Employer_____

Date Of Birth_____ Age_____Male_____ Female_____

Patient's SSN_____ If Patient is a Child, Parent's Name_____

Referred By_____ _____

Person Responsible for Bill

Name_____
Last First Middle Initial

SSN_____ Date of Birth_____ Spouse's name_____

Address_____ City, State & Zip_____

Phone: Home_____ Work_____ Cell_____

Occupation_____ Employer_____

Emergency Contact

Name _____ Best number for contact_____

Relation to patient _____

Insurance Information

Primary Medical Insurance Company_____ Member ID Number_____
Group Number_____ Member Name_____ D.O.B _____
Member Employer_____

Secondary
Medical Insurance Company_____ Member ID Number_____
Group Number_____ Member Name_____ D.O.B _____
Member Employer_____ Is there tertiary insurance? _____

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Patient Financial Responsibility

It is the policy of this office to help keep your health care costs to as low as possible. In order to do this, we need to keep our billing costs to a minimum. *Please help us in the following ways:*

- ALWAYS bring your current health insurance card to the office
- Please notify us at appointment of any changes in insurance, address, phone #, etc.
- Please pay your co-payment on day of service; or if you do not have insurance, please come prepared to pay for your visit in full
- You should receive a bill for any patient responsibility within 30 days; and/ or an explanation of benefits from your insurance carrier, if you do not, please contact our biller.

Payments: Unless we approve other arrangements in writing, the balance on your statement is *due and payable when the statement is issued*. You will have two weeks from the time billed to pay your statement. *ALL late statements are subjected to a $5.00 late charge for every two weeks that the statement is not paid. If the statement is not paid in full after 6 weeks, then it will be sent to collections.*

Payment options if you have insurance: We are required by our insurance contracts to collect ALL co-payments **on the day of service**. *Any co-payments that are not paid on the day of the visit will be subject to a $10.00 co-payment processing fee.*

Payment options if you have no insurance: For your convenience we accept cash, debit and credit card payments on the day that treatment is provided.

Insurance: It is the responsibility of the cardholder to know what the eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to the appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.

Divorced/Separated parents: In case of divorce or separation. The parent authorizing the treatment for a child/ children will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, *it is the authorizing parent's responsibility to collect from the other parent*.

Returned checks: There is a $25.00 fee for any checks returned by the bank for insufficient funds.

Waiver of Confidentiality: You understand if the account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past-due status is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

Having read the above financial information, I request the services be performed. I also agree to be ultimately responsible for charges incurred for myself or my child/ children as their legal parent or guardian.

_____ Date _____

Patient or Representative's Signature

Relationship to patient _____

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Release for Appointment Reminders

I, _____ (Print), hereby authorize “Foundations Holistic Therapy” to send me an

appointment reminder via e-mail or text message using the following information.

Email reminders may contain patient or clinic information such as,

but not limited to, patient first name and clinic location.

Patient / Guardian Contact Information:
(Please print clearly and legibly)

E-mail: _____

Cell phone: _____

Patient / Guardian (Print): _____

Signature: _____

Date:

Note to Office Managers:
Confirm that the E-mail and Cell Phone provided above match the information in the patient information screen.

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NOTICE OF PRIVACY PRACTICES

In our office we understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

Make sure that health information that identifies you is kept private
Give you this Notice of our legal duties and privacy practices with respect to health information about you and follow the terms of the Notice that is currently in effect

How we may use and disclose health information about you:

For treatment
For payment
For health care operations
For appointment reminders
Requesting insurance information
In dispensing glasses and contact lens prescriptions
As required by law
Public health risks
Health oversight activities
Lawsuits and disputes
Law enforcement
Coroner, health examiners and funeral directors
To avert a serious threat to health and safety
As required by the Military or Veterans
National Security
Worker's Compensation
Offsite storage of records

Your rights regarding Health Information about you:

Right to inspect and copy
Right to amend
Right to an Accounting of Disclosures
Right to Request Restrictions
Right to Request Confidential Communications
Right to a Paper copy of this Notice (full Notice is available upon request)
Right to deny disclosure to a health plan if you have paid for services out of-pocket.

Changes to this Notice:

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date on the first page. Effective July 17 2018

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact our Office Manager to file a complaint.

Acknowledgement of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.