Purity of Life

Meeting You Where You Feel @ Home!

Welcome. Thank you for choosing Purity of Life for your medical needs!

The information contained in this letter is for your benefit, please read carefully.

Your Provider will be Aimee Gregorie Bachelier, ND. Her practice and experience is in Naturopathic Medicine. We offer many Natural alternative solutions for Pain Management.

Our concern is your well being and our ability to provide you and all members of your family with superior healthcare. In order to do this we must have the cooperation and understanding of you, our patient.

Purity of Life is open by appointment only. We offer same day appointments and home healthcare. We are closed on all federal holidays.

Members of our staff are available to take your calls Monday through Thursday, 8am-5pm. Bearing in mind, calls are returned on the severity of need. If your call cannot be taken immediately, please understand that we are working hard to ensure excellent care to all our patients. We will return your call as soon as possible. The doctor is available after office hours, for emergencies only.

Payment is due at the time of service. Processing fees apply to Credit (3%) and Returned Checks ($15). Receipts are sent electronically, printed upon request.

If you have insurance, we will happily hand you a service summary for your submittal. Please be advised, it is your responsibility to know the terms and conditions of your insurance, and whether or not the provider you are seeing is covered. Patients are responsible for all charges. If there is a dispute with your insurance company or any third party regarding reimbursement, Purity of Life and Dr. Bachelier are not responsible.

A 24-hour notice for reschedule or cancellation is required. There is a charge for all missed appointments ($25).

Thank you for your time and assistance in this matter. We look forward to working with you.

Purity of Life

PLEASE COMPLETE THE ATTACHED FORMS PRIOR TO YOUR APPOINTMENT.

X____

Your signature indicates acknowledgement and understanding of information given.

Aimee Gregorie Bachelier, ND ▪ Phone: 520-909-0703 ▪ Fax: 520-842-2133

Consent Agreement

Consent to the Use and Disclosure of Health Information for;
Treatment, Payment, or Healthcare Operations.

I, ______________________________________, understand as part of my healthcare, this practice (Purity of Life) originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care
- A source of information for diagnosis and surgical information for my service invoice
- A means by which a third-party payer can verify services billed were actually provided
- A tool for routine care operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with the *Welcome Letter* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the letter prior to signing this consent. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, healthcare operations and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I fully understand and accept\decline the terms of this consent.

______________________________ _____/_____/_____
Signature Date

FOR OFFICIAL USE ONLY

[ ] Consent received by: ___________________________________

[ ] Consent refused by patient, and treatment refused permitted.

[ ] Consent added to the patient’s medical record on _____/_____/_____

Aimee Gregorie Bachelier, ND ■ Phone: 520-909-0703 ■ Fax: 520-842-2133