HEALTH + WELLNESS
equilibrium

Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

_____ _____

Patient Signature Date

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment**
  We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
- **Payment**
  We may use and disclose your medical information for payment purposes.
- **Health Care Operations**
  We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

You have a right to:

- Inspect and get copies of your protected health information. (You must make your request in writing).
- Receive an accounting of disclosures of your protected health information
- Request that we place additional restrictions on our use or disclosure of your protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it (except in the case of an emergency).
- Reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- Request that we change your protected health information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used.

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Patient Name Birthdate

_____ _____

Patient Signature Date

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Patient Financial Responsibility Contract

This is a legally binding contract between Equilibrium Health + Wellness and you. The words, *I, me, my, you and your* all refer to the patient.

- I agree to be financially responsible for payment of Equilibrium Health + Wellness' services. Cash or credit cards are acceptable forms of payment for these services.
- Current insurance cards must be presented at every office visit. Equilibrium Health + Wellness is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.
- I agree to give Equilibrium Health + Wellness my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or delay in payment. I agree to pay Equilibrium Health + Wellness the balance on my account after my insurance claim has been processed.
- I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.
- I understand that all services provided to me by Equilibrium Health + Wellness are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.
- I understand that my insurance may or may not agree to the usual, customary, or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.
- If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.
- Equilibrium Health + Wellness has a contract with my insurance company. Equilibrium Health + Wellness will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.
- I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Equilibrium Health + Wellness my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Equilibrium Health + Wellness pursuing any collection means possible.
- If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

- I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company.
- If the reason for appointment is related to work injury or auto accident, I agree to give Equilibrium Health + Wellness the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Equilibrium Health + Wellness can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.
- I understand I am subject to a $50 cancellation/no show fee if I do not provide a 24 hour notice of cancellation, or if I am more than 15 minutes late to my scheduled appointment time.
- I understand I will provide a valid credit card, to be placed on file.

I have read and I understand Equilibrium Health + Wellness' financial policies and I accept responsibility for the payment of any fees associated with my care.

Card#: _____ Expiration: _____ /_____ Billing Zip Code: _____

_____ _____

Patient Signature Date