HealthStrong Integrative Medicine, PLLC.

Consent for Treatment

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use of disclosure of my identifiable health information by the HealthStrong Integrative Medicine, PCCL for the purposes of diagnosis or provising treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at HealthStrong Integrative Medicine, PLLC may be conditioned upon my consent as by my signature on this document. Practitioner means a Naturopathic Doctor, Acupuncturist, Medical Doctor, Chiropractic Doctor, Osteopathic Doctor, Massage Therapist or other healthcare worker employed by or under contract with the HealthStrong Integrative Medicine, PLLC.

Patient means any person seeking the health care advice and/or treatment of a practitioner at the HealthStrong Integrative Medicine, PLLC through consultation by phone or in person.

My identifiable health information means health information collected from me and created or received by my practitioner, another health care provider, a health plan, and my employer. This identifiable health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. HealthStrong Integrative Medicine, PLLC is not required to agree to the restrictions that I may request. However, if the HealthStrong Integrative Medicine, PLLC agrees to a restriction that I request, the restriction is binding upon the HealthStrong Integrative Medicine, PLLC. I have the right to revoke this consent, in writing, at any time except to the extent that the HealthStrong Integrative Medicine, PLLC has taken action in reliance of this consent.

I understand that I have the right to review the HealthStrong Integrative Medicine, PLLC Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of HealthStrong Integrative Medicine, PLLC.

HealthStrong Integrative Medicine, PLLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit.

Emergency Care:

Our clinic does not administer emergency medical care. In the case of an emergency, please see your family physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

Payment is expected in full at time of service. We accept personal checks, cash, Visa, Mastercard, and American Express.

We are currently able to bill some insurances in the states of New Hampshire.

- Upon request, an invoice can be produced which may be submitted to insurance companies for reimbursement by the patient. Please ask for this invoice at time of payment.
- The HealthStrong Integrative Medicine, PLLC does not guarantee reimbursement by the patient's insurance company.
- I understand that it is not the responsibility of the HealthStrong Integrative Medicine, PLLC to research whether reimbursement may occur, to submit forms for reimbursement, or to follow up with my insurance company regarding reimbursement.

Cancellation Policy:

The HealthStrong Integrative Medicine, PLLC requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the full visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.

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Signature of Patient or Authorized Representative Date

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Printed name and relationship to patient

THANK YOU