Hands On
Natural
Medicine

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PATIENT RESPONSIBILITY

I understand that it is my responsibility to keep my provider fully informed of health concerns or history and to take an active part in achieving optimal health by following her recommendations. To notify my provider of any problems or concerns regarding treatment. To keep my provider informed of other medications I am using and all treatment recommendations from other practitioners. Finally, to be familiar with and agree to abide by the most current financial policy and to keep my account up to date and paid in full.

X_____ Date _____
Patient or Guardian Signature

RELEASE OF INFORMATION

All information provided herein is true and correct. I hereby consent to treatment.

I give permission to my provider and staff to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons.

I have read and understand the above release.

X_____ Date _____
Patient or Guardian Signature

ASSIGNMENT OF BENEFITS

I authorize payment directly to my provider and their affiliates for services rendered to me. I understand and agree that health and accident policies are a contract between my insurance company and myself. **I also understand that if my insurance provider refuses payment, my services are not billable to insurance or my deductible has not been met, I am directly and fully responsible to said provider to all bills submitted by them for services rendered to me. I understand that all co-payments (and any applicable supply charges) are due at time of service. I understand that a finance fee of 5% will be charged for any balances due past 30 days.**

X_____ Date_____
Patient or Guardian Signature

APPOINTMENT CANCELLATION AGREEMENT

I understand that twenty-four (24) hours notice is not only appreciated, but also required when canceling an appointment. I also understand that I will be charged for missed appointments that I do not cancel, and agree to pay for such. **Standard charge is $50.**

X_____ Date_____
Patient or Guardian Signature