**Integrative Health and Wellness, LLC**
**6910 N. Main St. Suite 6**
**Granger, IN 46530**
**574-330-0464**

| **Patient Information** | |
|---|---|
| Name: | Home Phone #:<br><br>Cell Phone # : |
| DOB: | Email Address: |
| Address:<br><br>City: Zip Code: | Emergency Contact Name :<br><br>Phone #:<br><br>Relation: |
| Marital Status: S M D W | |
| Gender: Male/Female | Primary Care Physician:<br>Address:<br>Phone # : |
| Primary Insurance: Yes No | |
| Insurance Company: | |
| | |

**Medical Information Release**

I hereby authorize INTEGRATIVE HEALTH AND WELLNESS LLC to release any medical or appointment information to the following persons (i.e. – spouse, parents, children or significant other):

Name Relationship

1.______________________________________________________________

2.______________________________________________________________

3.______________________________________________________________

**Consent for Treatment**

I hereby consent to and authorize INTEGRATIVE HEALTH AND WELLNESS, LLC, its associated physician's, nurse practitioners, students and other healthcare providers, to provide and perform such medical, tests, procedures, drugs and other services and supplies as are considered advisable by such health care providers for my health and well-being. If I should not comply with the medical program of care provided or recommended by physicians(s) , or designated alternates(s), I understand that I then relieve my physician(s), designated alternate(s), associated medical staff, and the practice of all responsibility resulting from my action.
As parent/guardian, I give my permission to consult with and/or treat ______________________________________________.

INTEGRATIVE HEALTH AND WELLNESS, LLC requires a 24 hour notice for all appointment cancellations. Cancellations with less than 24 hour notice will result in a fee of 50% of the services scheduled and no shows will be charged at 100% of services scheduled. Excessive cancellations or no shows for appointments may result in a discharge from the practice.

**Patient Financial Responsibilities**

It is important that you understand your financial responsibilities for the services you receive. The changing healthcare environment puts more of this responsibility in your hands. We will be glad to discuss your account with you at anytime. Your responsibilities are outlined in this document. We ask you to read, agree to, and sign below prior to any treatment.
**Insurance:** You should bring your insurance card with you to every visit and make us aware of any changes in coverage. We also require a copy of your driver's license to confirm identity. Additionally, if your insurance company requires a physician referral, it is your responsibility to ensure that it has been obtained. If it has not, you will be asked to sign a waiver.<u>You must notify us if you have and/or receive any Medicaid benefits.</u>
**Cash Accounts:** We do not carry balances on accounts you are expected to pay at the time of service for all services. For your convenience, we accept cash, personal checks, Visa, Master Card, and Discover.
**Missed or Cancelled Appointments:** These are both subject to fees as states above. The credit card on file with the office can be charged for these occurances.
**Minor Patients:** For patients 17 years old and younger, a parent or guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors) It is the parent or guardian's responsibility to bring the necessary health information and to make payment at the time of service

**Returned Checks:** $35 NSF will be applied to the patient's account. If you present two (2) checks that are returned to us, we will require cash for future services.

**Non-Covered Services: S**ome service(s) provided are not covered by insurance or may be deemed medically unnecessary, experimental, non-covered and/or inclusive. The patient agrees to pay for these services.The patient accepts the responsibility to know their plan's provisions. And, the patient waives the right to be informed of plan exclusions or service that may be considered medically unnecessary (as defined by the patient's health plan), or non- covered services prior to receiving services.

Our charges are determined by what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. If you have any questions about your insurance, we are happy to assist you. Please contact our office at (574) 330-0464. Specific coverage issues, however, should be directed to your insurance company's member service department (number found on back of card).

I acknowledge my understanding and agree that I am legally responsible for my account and all costs associated with the collection of my account. Account balances must be paid in full at time of service. I also authorize the practice, all associated physician and all associated agencies, to gather, maintain and release any and all of my information that may be required for the processing of any and all claims for third party payers.

I authorize INTEGRATIVE HEALTH AND WELLNESS, LLC to release information concerning illness or treatments to my insurance carrier, to submit fees for services rendered to my insurance for payment, and also direct payment to the PROVIDERS(s) who rendered medical services. I will accept responsibility for payment of fees submitted to my insurance carrier, and for any balance not covered by my insurance.

**Acknowledgment of Receipt of Notice of Privacy Practice**

Direct any questions to 574-330-0464.

I have been presented with and received the Notice of Privacy Practices for INTEGRATIVE HEALTH AND WELLNESS, LLC

I have been presented with and choose not to receive the Notice of Privacy Practices for INTEGRATIVE HEALTH AND WELLNESS, LLC

I understand that this Notice of Privacy Practice may change over time and that the obligations of INTEGRATIVE HEALTH AND WELLNESS, LLC, and my rights under it may change.

Refusal: Patient or guardian of patient refused to acknowledge receipt of the Notice of Privacy Practices of INTEGRATIVE HEALTH AND WELLNESS, LLC.

Acknowledgment of receipt of the Notice of Privacy Practices was not obtained, despite INTEGRATIVE HEALTH AND WELLNESS, LLC's good faith effort because:_________________________________.

Print:_________________________________________________ ___________________________

Patient or Responsible Party Date

Signature: ____________________________________________ ____________________________

Patient or Responsible Party Date

Signature: ____________________________________________ ______________________________

Witness Date

Name: _______________________________________________ Birthdate: ________________