Consent for Treatment

Name: ____ Date of Birth: _____________

Address: ____
May I leave a message with a person or on a recording? Yes or No please check appropriate box

Ph Day ( ) ___________________________ □Y □N Eve ( ) ___________________________ □Y □N

E-Mail Address: ___________________________Web: ____
In Case Of Emergency Contact:

Name: ____ Relationship: ______________________

Phone: Day ( ) _____________________________________ Eve: ( ) ______________________

I am willing to be part of a team for wellness. If I do not plan to follow my physician's advice, I will tell her. As a team, we may find a work-a-round to any part of the treatment I may not agree with or find difficult to comply with. I understand that I may refuse any and all services at any time. **I will also inform this clinic of all other types of treatments, herbs and over the counter substances, I am taking; if I become pregnant; if I am diagnosed with Hepatitis, AIDS, or an STD.** I have read this information. I understand that all clinical information will be kept strictly confidential. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I agree to indemnify, protect, save, and hold harmless Solara Attatharya from any and all liability pursuant to any and all outcomes that may arise either to myself or to any minor and/or incompetent for whom I am legally claiming responsibility and hereby charge my heirs to honor this agreement. Please Initial_____________________

Solara Attatharya, AP, is involved in research and in the training of other physicians. In some cases, she may want to use some or all of the information gathered in my case to share in this research, classes or Internet consultation. I consent to the use of photo's, video or audio taping for these purposes. My name and other personal information, which may identify me, will be removed to maintain my confidentiality. □**I do** □**I do not** give permission for details of my case to be used. Initials: -
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(I) declare that I do not now, nor have I ever, participated in any investigative way, in conjunction with or in cooperation with, any city, county, state, or federal government agency or any other human entities; for any purposes of entrapment or investigation purposes directed at or involving any individuals, persons, or entities who are involved with health, medical, or other matters. Initials:_____________________

Financial Responsibility

I understand even if I have insurance coverage, I am responsible for all fees connected with services rendered by Solara Attatharya and I agree to make payment in full at the time services are provided unless prior arrangements have been made. Returned checks and balances older than 30 days are subject to collection fees and interest charges. I am aware that I am liable for all legal expenses incurred with the collection of the account.

Cancellation Policy Please give 2 business days notice LESS THAN 48 BUSINESS HOURS NOTICE one free pass. The second time will be billed at 50% of the consultation fee and 100% thereafter. *Your appointment time is reserved. If you miss your appointment, others who desire that appointment time cannot be served.* Fees for missed appointments are NOT covered by insurance.

Please be on time. Try to call if you are running late. (Your appointment time may get shorter by the amount of time you are late or rescheduled.) If you are ill, please call us prior to your appointment and discuss it with us. Acupuncture can safely be utilized with almost all illnesses.

I consent and authorize Solara Attatharya to transmit any information to my insurance company as required or requested for Solara to receive insurance compensation in connection with my own or my child's treatment. My signature below indicates that I have read and agree to all of the above:

Signature of Client or Guardian ____ Date: ______________

HIPPA Privacy Agreement Abundant Health Holistic Center

Statement of HIPAA: Consent for Use and Disclosure of Health Information as required by law of medical and other clinics

We are very concerned with protecting your privacy and will keep disclosure of any health info to a minimum. Please review this policy before signing below. You have a right to a copy of this policy. We reserve the right to change our policy practices as described in this notice. Notice of any changes will be posted in the office.

There are several circumstances in which we may have to use or disclose your health care information.
We may have to disclose your health information to another health care provider or to a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your condition or they referred you to us.

We may have to disclose your health information and billing records to another party if they may be responsible for payment or collection of payment for services provided you at this clinic.

We may need to use your health information within our practice for quality control or other operational purposes. Among other items, this may include telephoning or mailing appointment reminders or periodic greetings such as birthday or holiday cards. By signing this form, you are giving authorization to contact you with these reminders and information.

Your right to limit uses of disclosures includes the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding with us.

Additionally, you may revoke your consent to us at any time; however, your revocation must be in writing. We will not able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Patient name: ____ Date of Birth: _________________

Patient Address: ____ Apt # ______

City, State Zip ____
Type of PHI to be restricted or limited (Please check all that apply) Checking these means this information can't be verified or released to anyone **including family members** unless you sign more papers. How would you like your PHI restricted? ☐ No Restrictions ☐ Restrictions

☐ Home Phone # ☐ Patient History ☐ Home Address ☐ Office Address
☐ Occupation ☐ Office Phone # ☐ Name of Employer ☐ Spouse's Name
☐ Visit Notes ☐ Spouse's Ofc Ph # ☐ Hospital Notes ☐ Prescription Info
☐ Other ____

Please list any others (Physicians, spouse, family members, and or friends to whom we may release your private health information to:

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I acknowledge that I was given the opportunity to read a copy of the Notice of Privacy Practices either electronically or in print and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.
I understand that this form will be placed in my records for six years. Date Expires: ______2020

____ _________________________
Signature of Patient or Legal Guardian Date