# 2024 Consent for Treatment

**CONSENT**
I voluntarily give permission to the healthcare professionals at Biologic Healthcare LLC (BH) to provide me (or my dependent listed below) with medical and/or counseling services. I understand that by signing this form, I am authorizing the providers to treat me for as long as I seek care from BH or until I withdraw my consent in writing. I understand that my healthcare at BH may include general medicine, acupuncture, botanical medicine, chiropractic, homeopathy, laboratory tests, diagnostic imaging referrals, massage therapy, naturopathic medicine, nutritional assessment, physical therapy and psychotherapy. I realize that no guarantees of results or outcomes have been given to me by the providers at BH.

**STATEMENT OF FINANCIAL RESPONSIBILITY**
I understand that I am legally responsible for all charges accrued in connection with the care and treatments provided by the practitioners at BH. I certify that I (or my dependent) have coverage by the insurance listed with the practice.

I authorize payment directly to BH for health insurance benefits payable to me under terms of my policy and I agree to assist in the processing of claims for benefits. I understand that my insurance carrier will not cover the cost of dietary supplements and may not approve or reimburse services in full, due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I understand that I am responsible for fees not paid in full, co-payments and policy deductibles (when applicable) and co-insurance, except where my liability is limited by contract.

**CHANGES IN INSURANCE CARRIER OR POLICY CHANGES**
I will notify the front desk when I arrive of any changes to my insurance carrier or any policy changes. I understand that I am responsible for knowing my insurance coverage and for notifying Biologic when changes occur. I also understand that I am responsible for any charges that are denied by my previous insurance company and denied by the new insurance due to timely filing issues.

For billing questions, contact Mid-Vermont Medical Billing at (802) 773-0250

**PAYMENT**
Payment for supplements, co-pays, deductibles and services not covered by insurance is due at the time of your visit. Currently, BH accepts cash, check and credit/debit cards. Returned checks will be charged a service fee of $50.00. Unpaid balances over 30 days may be charged late fees. We understand that patients may experience occasional financial problems. Please speak with us before the time of service regarding such circumstances. If an invoice exceeds 121 days from the date of service, the account may be sent to collections and a fee of $75.00 will be added to the invoice. If an account is sent to collections, the patient will be dismissed from the practice.

**SELF PAY, NO SURPRISE ACT and GOOD FAITH ESTIMATES**
The No Surprise Act requires us to provide a quote to patients who have out-of-network insurance plans. New patient appointments range from $180-$320, depending on the time spent or complexity of the health concerns. Follow up visits range between $115-$235, excluding the cost of procedures. Our office is always happy to answer any questions.

**CANCELLATIONS AND RESCHEDULING**
If you must reschedule or cancel an appointment, **please give at least 24 hours notification**. If you fail to present or provide notification for a new patient visit or preventive visit/physical exam (1 hour) or follow up visit (30 minutes), you may be changed a $150 or $75.00 no-show fee. A patient who is a no-show more than three times may be dismissed from the practice. Your visit with BH begins at the stated time of your appointment. Please arrive 10 minutes early or confirm you are able to login to our HIPAA compliant telemedicine platform before the start of your visit. A patient more than 15 minutes late for an appointment who has not contacted the office will be charged a $75.00 no-show fee.

**PRESCRIPTION AND TINCTURE REFILLS**
A 72 hour notice is required for refilling prescriptions and tinctures.

(continued)

## CONSENT FOR RELEASE OF PRIVATE HEALTH INFORMATION

I understand a confidential record will be kept of health-related information and services provided to me. This record will not be released to others unless directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and request a copy. An "Authorization to Release Personal Healthcare Information" must be signed and kept on file prior to release of records. BH will process requests within 30 days. Records longer than 50 pages will be accessed a $0.25 per page printing fee.

## NON-COVERED SERVICE WAIVER

Private insurance will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If your insurance company determines that a particular service or treatment is "not reasonable and necessary" they will deny payment for that service or treatment unless explicitly stated that such service or treatment would be otherwise covered. Check with your insurance company. In these circumstances, a bill is not submitted to your insurance company and charges are your responsibility. Some examples of non-covered services include, but are not limited to:

- Most laboratory studies related to functional medicine, including food sensitivity testing, measuring IgG. We can provide relevant codes if you plan to submit for possible reimbursement.
- Intramuscular injections of minerals, vitamins and/or botanicals, such as B12 or B Complex.
- Nutritional supplements and botanical products.
- Acupuncture

(continued)

# Acknowledge of Receipt

## 2024 CONSENT FOR TREATMENT AND INSURANCE INFORMATION

Do you give Biologic Healthcare consent to access your prescription history? ❐ YES ❐ NO

Please sign and date below confirming that you have read, understand and agree to all statements and policies on pages one and two and have had opportunity to ask questions. Please understand that fees and policies may change and that patients will be notified of such changes. Note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices (available at biologichealthcare.com or in the office).

Print Patient Name:

Print Your Name If Signing For Patient:

Relationship to Patient:

Signature: Date:

(patient/client, or authorized representative, parent/legal guardian)

**PRIMARY**

Insurance:

Member ID #: Group #:

Subscriber/ Policyholder Name: Your Relationship to Subscriber

Subscriber / Policyholder Date of Birth: SSN:

**SECONDARY**

Insurance:

Member ID #: Group #:

Subscriber/ Policyholder Name: Your Relationship to Subscriber

Subscriber / Policyholder Date of Birth: SSN:

sensible approaches to your well-being
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