Consent for Treatment

I voluntarily give my permission to the healthcare providers at Biologic Healthcare LLC (BH) to provide me with medical 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 with BH may include acupuncture, botanical medicine, general family medicine, homeopathy, laboratory/ diagnostic imaging referrals, massage therapy, naturopathic medicine, and nutritional assessment. With this knowledge, I realize no guarantees have been given to me by the providers at BH.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am legally responsible for all charges in connection with the care and treatments provided by the practitioners at BIH. I certify that if I, and/or my dependent, have insurance coverage, I authorize payment directly to BIH 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.

PAYMENT

Payment for all services (copays / deductibles) and supplements **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 $30.00, and 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 any such circumstances.

CANCELLATIONS AND RESCHEDULING

If you need to reschedule or cancel an appointment, **please give at least 24 hours notification**. If you forget an appointment or cancel less than 24 hours prior you will be charged a $75.00 fee for a follow-up/acute visit OR $150.00 for a physical exam/annual preventive medicine visit/new patient appointment. A patient who is a no-show for more than three visits may be considered for dismissal from the practice.

AMBIENT AI MEDICAL NOTE-TAKING

I understand that the practice may use ambient or automated transcription technology to assist with medical note-taking during my visits. This technology is intended to improve accuracy and efficiency of documentation. I consent to the use of this tool with the understanding that my information will be handled in compliance with privacy and security laws, that recordings (if used) will not be retained longer than necessary for documentation, and that I may decline or withdraw this consent at any time without affecting my care.

CONSENT FOR RELEASE OF PRIVATE HEALTH INFORMATION

I understand that a confidential record will be kept of the health 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 obtain a copy of my record upon request. A "RELEASE OF RECORDS" must be signed and kept on file prior to the release of any records.

PRESCRIPTION AND TINCTURE REFILLS

A 72 hour notice is required for refilling prescriptions and tinctures.

Do you give Biologic Healthcare consent to request your Rx history? ❒ Yes ❒ No

AGREEMENT

Please sign and date below that you have read, understand and agree to the above policies. Fees and policies may change and patients will be notified of any such changes.

Print Name: ____________________

Signature: ____________________ Relationship to patient: ____________________ Date: ____________

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