

BIOLOGIC INTEGRATIVE HEALTHCARE LLC  
DBA Biologic Healthcare (BH)  
PATIENT CONSENT, FINANCIAL  
RESPONSIBILITY & PRACTICE POLICIES  
**CONSENT FOR TREATMENT**

I voluntarily give my permission to the healthcare providers at **Biologic Healthcare (“BH”)** to provide me with healthcare services. I understand that my consent authorizes BH providers and appropriately supervised clinical staff to evaluate, diagnose, treat, and manage my healthcare needs for as long as I receive care from BH, unless I withdraw my consent or my relationship with the practice ends.

I understand that my healthcare at BH may include, as clinically appropriate, general family medicine, naturopathic medicine, acupuncture, botanical medicine, homeopathy, nutritional assessment and counseling, laboratory testing and referrals, diagnostic imaging referrals, massage therapy, and other services within the scope of practice of the treating clinician.

I understand that healthcare and medical treatment cannot be guaranteed to produce a particular result or outcome. No guarantees or warranties regarding the outcome of treatment have been made to me by BH or its providers.

I understand that I have the right to ask questions about my proposed care, the risks and benefits of treatment, reasonable alternatives, and the expected course of treatment. I understand that I have the right to refuse or discontinue treatment to the extent permitted by law.

#### **STATEMENT OF FINANCIAL RESPONSIBILITY**

I understand that I am financially responsible for all charges for healthcare services, products, supplements, laboratory services, procedures, and other items provided to me or on my behalf by Biologic Healthcare LLC and/or its practitioners, except to the extent that payment is made by an insurance plan or other third-party payer.

If I have health insurance, I authorize BH to submit claims and, when applicable, to receive payment directly from my insurance carrier for covered services provided to me. I authorize the release of information reasonably necessary for BH to process claims, obtain payment, determine eligibility and benefits, obtain prior authorization when applicable, and otherwise carry out treatment, payment, and healthcare operations.

I understand that verification of insurance eligibility or benefits by BH does not guarantee that my insurance company will pay a claim. I am responsible for understanding my insurance benefits, including deductibles, copayments, coinsurance, exclusions, limitations, prior authorization requirements, network restrictions, and other plan requirements.

I understand that insurance companies may deny or reduce payment for services for a variety of reasons, including lack of coverage, benefit exclusions, medical necessity determinations, authorization requirements, deductible or coinsurance obligations, limitations on reimbursement, or charges exceeding the insurer’s allowed amount.

I understand that dietary supplements, nutritional products, botanical products, and other products may not be covered by my insurance and are generally my financial responsibility.

I agree to pay any patient responsibility, including applicable copayments, deductibles, coinsurance, non-covered services, and balances that are my responsibility under my insurance plan, except where my liability is otherwise limited by applicable law or contract.

# CONSENT FOR TREATMENT CONTINUED

## CHANGES IN INSURANCE OR DEMOGRAPHIC INFORMATION

I agree to notify BH promptly of any changes to my insurance coverage, insurance carrier, policy, address, telephone number, email address, or other information necessary for billing and communication.

I understand that failure to provide current insurance information may result in claims being submitted late or to the wrong insurance carrier. I understand that I may be responsible for charges that are denied because accurate or up-dated insurance information was not provided to BH in a timely manner, including claims that become untimely due to a change in insurance coverage.

I understand that I am ultimately responsible for providing accurate insurance information and understanding the requirements of my insurance plan.

## PAYMENT

Payment for applicable copayments, deductibles, coinsurance, self-pay services, supplements, products, and other patient-responsibility amounts is due at the time of service or purchase unless other arrangements have been approved in advance by BH.

BH currently accepts cash, check, and credit/debit cards. Returned checks may be subject to a **\$30 returned-check fee**.

Balances that remain unpaid may be subject to additional fees or collection activity to the extent permitted by applicable law and BH policy.

If I am experiencing financial hardship or anticipate difficulty paying for care, I agree to contact BH **before the date of service whenever possible** to discuss available options. Financial arrangements must be approved by BH in advance and are not guaranteed.

## NON-COVERED SERVICES & PATIENT FINANCIAL RESPONSIBILITY

I understand that insurance coverage varies by plan and that Biologic Healthcare cannot guarantee that any service, treatment, laboratory test, injection, or product will be covered or reimbursed by my insurance.

The following services and products are generally **not submitted to insurance** and are the patient's financial responsibility:

- Functional and specialty laboratory testing, including certain food allergy/sensitivity, IgE, and IgG testing. Applicable billing codes may be provided upon request for patients who wish to seek reimbursement independently.
- Intramuscular injections of vitamins, minerals, nutrients, and/or botanicals, including B12 and B-complex.
- Nutritional supplements, professional-grade supplements, botanical products, and other products purchased through BH.

I understand that insurance coverage may vary and that I am responsible for charges for non-covered or self-pay services and products that I elect to receive, to the extent permitted by applicable law.

## GOOD FAITH ESTIMATE / SELF-PAY PATIENTS

If I do not have health insurance or choose not to use my health insurance to pay for healthcare services, I understand that federal law may require BH to provide me with a **Good Faith Estimate** of expected charges for scheduled services or upon request, subject to applicable requirements and timeframes.

I understand that a Good Faith Estimate is an estimate of expected charges and is not a guarantee of the final cost of care. Additional services or healthcare needs that could not reasonably be anticipated at the time of the estimate may result in additional charges.

I understand that federal law may provide certain rights to dispute a bill that is substantially higher than a Good Faith Estimate under applicable circumstances.

# CONSENT FOR TREATMENT CONTINUED

## CANCELLATIONS, NO-SHOWS AND RESCHEDULING

We understand that circumstances sometimes arise that require an appointment to be cancelled or rescheduled. We ask that patients provide **at least 24 hours' notice** whenever possible.

If an appointment is cancelled with less than 24 hours' notice or the patient does not attend the scheduled appointment, BH may charge the following administrative cancellation/no-show fee:

- **\$75** – follow-up or acute visit
- **\$150** – physical examination/annual preventive visit or new patient appointment

These fees are administrative fees for reserving clinical time and are generally **not submitted to insurance**. The patient is responsible for payment of these fees.

Repeated missed appointments may interfere with our ability to provide care and may result in modification of scheduling privileges or consideration of dismissal from the practice. A patient who has more than three no-show appointments may be considered for dismissal, subject to applicable law and BH's dismissal policy.

BH recognizes that emergencies and extraordinary circumstances occur. Patients are encouraged to contact the office as soon as possible when an unavoidable circumstance prevents attendance.

## LATE ARRIVALS

Patients are encouraged to arrive **10 minutes before their scheduled appointment time** and to allow adequate time for traffic, parking, and locating the office in downtown Brattleboro.

If a patient arrives **more than 5 minutes after the scheduled appointment time**, BH reserves the right to cancel and reschedule the appointment when the remaining appointment time is insufficient to provide appropriate care without adversely affecting the patient or other scheduled patients.

A late arrival may therefore result in a cancellation/no-show fee when applicable.

We will make reasonable efforts to accommodate late arrivals when the schedule permits, but accommodation cannot be guaranteed.

## PRESCRIPTION AND TINCTURE REFILLS

A minimum of **72 business hours notice** is requested for prescription and tincture refill requests. Some medications may require additional time due to pharmacy requirements, clinician review, prior authorization, or other circumstances.

Refill requests should be made during normal business hours whenever possible. Refills are subject to clinical review and applicable prescribing requirements and are not automatically guaranteed.

### Prescription History

I authorize Biologic Healthcare to obtain and review my prescription medication history, including information available through applicable prescription monitoring programs and/or health information exchange systems, when permitted by law and clinically appropriate.

I understand that refusal to authorize access to prescription history may affect BH's ability to prescribe or safely manage certain medications.

# CONSENT FOR TREATMENT CONTINUED

## AUTOMATED MEDICAL NOTE-TAKING

I understand that Biologic Healthcare may use ambient or automated medical transcription technology to assist with clinical documentation during my visits.

These tools may listen to and/or process portions of a clinical conversation for the purpose of assisting with documentation. The purpose of this technology is to improve the efficiency and accuracy of medical documentation and does not replace the clinical judgment or responsibility of my healthcare provider.

I understand that:

- BH will use such technology in accordance with applicable privacy and security requirements and BH policies.
- The clinician remains responsible for reviewing and approving the medical record.
- Information collected through the technology will be handled in accordance with applicable privacy requirements and BH's Notice of Privacy Practices.

## COMMUNICATIONS BY PHONE, EMAIL, PATIENT PORTAL AND TEXT MESSAGE

I understand that BH may contact me using the telephone number, email address, patient portal, or other contact information that I provide for purposes including appointment scheduling, appointment reminders, prescription/refill communication, billing, care coordination, follow-up, and other communications related to my healthcare.

I understand that electronic communications may carry some privacy and security risks. I agree to notify BH promptly if my contact information changes.

BH will make reasonable efforts to protect my information, but I understand that no electronic communication system can be guaranteed to be completely secure.

## SMS/TEXT MESSAGE CONSENT

**By providing your phone number, you consent to receive SMS text messages from Biologic Healthcare for appointment reminders and general two-way communication. Message frequency varies, message and data rates may apply.**

I understand that:

- Consent to receive text messages is not a condition of receiving medical care.
- I may opt out of marketing text messages at any time.
- I may opt out of SMS messages by replying **STOP** to a message.
- I may request another communication method if I do not wish to receive text messages.
- Message frequency may vary depending on my interactions with BH.
- Standard message and data rates may apply depending on my mobile carrier and plan.

I understand that text messages may contain limited information and that BH will make reasonable efforts to avoid including unnecessary protected health information in text messages.

## CONSENT FOR RELEASE AND USE OF PRIVATE HEALTH INFORMATION

I understand that Biologic Healthcare will maintain a confidential medical record of the healthcare services provided to me.

I understand that BH may use or disclose my protected health information as permitted or required by applicable law, including for purposes of treatment, payment, and healthcare operations, and as described in BH's **Notice of Privacy Practices**.

I understand that certain disclosures may require my specific written authorization. When such authorization is legally required, BH may require me or my authorized representative to complete an appropriate **Authorization for Release of Health Information** before releasing records.

# CONSENT FOR TREATMENT CONTINUED

I understand that I have rights regarding my medical records, including the right to request access to and obtain copies of my records, subject to applicable law.

I understand that reasonable, legally permitted fees may apply to certain requests for copies of records.

## PATIENT RESPONSIBILITY FOR MEDICAL INFORMATION

I agree to provide BH with information that is accurate and complete to the best of my knowledge, including information regarding my medications, supplements, allergies, medical history, prior treatments, and insurance coverage.

I understand that my healthcare providers rely on the information I provide when making clinical decisions.

I agree to notify BH of significant changes in my health, medications, allergies, or other information relevant to my care.

## PATIENT RIGHTS AND WITHDRAWAL OF CONSENT

I understand that I have the right to ask questions about my care and to participate in decisions regarding my treatment.

I understand that I may withdraw optional consents, including consent for ambient AI documentation, marketing communications, and SMS/text communications, at any time. Withdrawal of an optional consent will not affect my eligibility to receive medical care, although it may affect how BH is able to communicate with me or document my visits.

I understand that withdrawal of consent for treatment may be subject to applicable medical, legal, and ethical requirements, including the need for appropriate continuity of care.

## AGREEMENT

By signing below, I acknowledge that I have read, understand, and agree to the policies and terms described in this document.

I have had an opportunity to ask questions and understand that I may request clarification regarding any portion of these policies.

I understand that BH's fees and policies may change from time to time. BH will provide notice of material changes in accordance with applicable law and its policies.

I understand that this document does not replace BH's Notice of Privacy Practices, financial policies, Good Faith Estimate requirements, or any separate authorization that may be required by law.