Center for Holistic Medicine
9 Brookwood Avenue Carlisle, PA 17015
(717)243-0616 FAX: (717)245-2351

Name: ______________________________ Phone: __________________

DOB: _______________________________

Center for Holistic Medicine

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Acknowledgement of receipt of Privacy Practices Notice:

I, __________________________ acknowledge that I have received a Privacy Practices Notice from the Center Holistic Medicine.

Patient Signature: _______________________ Date:______________

- I give authorization to release information to the following people:
  ______________________________ Relationship: ______________________
  ______________________________ Relationship: ______________________

- May we leave a message on an answering machine or with your spouse? Y/N
- May we use Email to communicate with other medical professionals? Y/N

If a personal representative on behalf of the individual signs this authorization, please complete the following:

Personal Representative's Name: ___________________________________

Relationship to Individual: ____

Signature Office Representative (office use only):

I attest that the above information is correct.

Signature:____________________________ Date:___________________________

Print Name: ___________________________ Title: __________________________

Center for Holistic Medicine Practice Policies

Effective October 2015

Office Policy:

We require a credit card number to be put on file to schedule appointments. To be considered an active patient an onsite visit must be made at least 1 time per year. All follow ups must be done in person or by telephone (as recommended by your physician)

Cancellation Policy:

All services are provided by appointment only and this scheduled time is for your exclusive use. Cancellation policy differs by type of appointment as written below.

Initial functional medicine/Autism Spectrum consult:

All new patients are required to give a **1 week cancellation notice** due to the length of the appointment and time spent by the physician reviewing your records. Center for Holistic Medicine retains the deposit of $150.00 as nonrefundable. If you do not call or just do not show up for your appointment you will be billed for the remaining amount of $150.00. These appointments are very involved and time consuming)

Note: Appointments can be rescheduled at the physician's discretion.

Acupuncture:

All new patient appointments are required to give a **1 week cancellation notice** prior to your scheduled appointment. Center for Holistic Medicine retains the $75.00 deposit as nonrefundable if cancellation policy is broken.

Note: Appointments can be rescheduled at the physician's discretion.

Follow up appointment Cancellation:

We require 48 hour notice for follow up cancellations for Functional Medicine/Autism Spectrum management which include office visits and telephone consults with the doctor. Center for Holistic Medicine retains the right to bill $100.00 of the standard fee for any consultation not cancelled within 48 hours prior to the visit.

Cancellation for follow up for Medical Acupuncture treatment:

We require a 48 hour notice for cancellation of follow up acupuncture visits. Center for Holistic Medicine retains the right to bill $50.00 of the standard fee for any consultation not cancelled within 48 hours of the scheduled visit.

Note: Fees for non-cancellation of follow up appointments are nonrefundable and may not be used as credit to a future consultation or procedure.

Signature ________________________________ **Date** ________________

Center for Holistic Medicine Practice Policies

Email Policies:

As a part of our effort to provide you with the very best medical care, our clinicians use emails as a form of communications with patients.

Note: Email is not HIPPA compliant and is not 100% secure.

Email Guidelines:

- Email communications is viewed as billable time, as in an office visit or telephone consultations.
- Any Email that requires at least 15 minutes of clinician time will be billed as per the clinician's discretion.
- Brief emails will not be billed individually, but frequent emails will be cumulative and left to the clinician's sole discretion when billing time is necessary.

Please note that if you choose to submit our invoices to your insurance company for reimbursement, telephone consults are not generally covered by insurance and email correspondence is not covered by insurance. You should not submit invoices for email correspondence to your insurance provider.

If you have any questions regarding any of these policies, please call us at 717-243-0616

Thank you,

If the patient is a child both parents/guardians must sign below.

I, ___________________________________ have read and understand the above outlined policies regarding email. I also understand that email is NOT 100% secure.

Patient Name: _____________________________________

Patient Signature: __________________________________ **Date: ______________**

Parent/Guardian Signature:__________________________________ **Date: ______________**

Parent/Guardian Signature:__________________________________ **Date: ______________**