CONSENT FOR TREATMENT

I voluntarily give my permission to the healthcare providers of Biologic Integrative Healthcare LLC (BIH) to provide me with medical or counseling services. I understand that by signing this form, I am authorizing them to treat me for as long as I seek care from Biologic Integrative Healthcare LLC or until I withdraw my consent in writing. I understand that my healthcare with BIH may include acupuncture, BEST (Bio Energetic Synchronization Technique), botanical medicine, chiropractic, EMDR (Eye Movement Desensitization Reprocessing), general family medicine, homeopathy, hydrotherapy, laboratory/ diagnostic imaging referrals, massage therapy, naturopathic medicine, nutritional assessment, physical therapy, and psychotherapy. With this knowledge, I realize no guarantees have been given to me by the providers at BIH.

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 Biologic Integrative Healthcare LLC. I certify that I, and/or my dependent, have insurance coverage with ___________________________________. I authorize payment directly to Biologic Integrative Healthcare LLC 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 serviced 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.

Primary Insurance:____

Insurance Address: ____Phone #: ____________________

Member ID #: ____ Group #: _______________________

Subscriber/ Policyholder name: ______________________________Your relationship to subscriber:__________

Subscriber/ Policyholder Date of birth: ____________________ SSN:________________________________

Secondary Insurance:____

Insurance Address: ____Phone #: ____________________

Member ID #: ____ Group #: _______________________

Subscriber/ Policyholder name: ______________________________Your relationship to subscriber:__________

Subscriber/ Policyholder Date of birth: ____________________ SSN:________________________________

PAYMENT

Payment for all services and supplements is due at the time of your visit. Currently, BIH accepts cash, check and credit/debit cards. Returned checks will be charged a service fee of $25.00, 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 hour notification. If you forget an appointment or cancel less than 24 hours prior you may be charged for the visit.

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.

Psychotherapy notes, created by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or group, joint or family counseling session will be maintained separate from the medical chart and will not be released without the signing of a separate "RELEASE OF MENTAL HEALTH RECORDS."

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.

Signature: _________________________________Relationship to patient__________ Date: __________

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