North Georgia NUTRITION & WELLNESS

INFORMED CONSENT

I consent to consultation/treatment at North Georgia Nutrition and Wellness, LLC as ordered by my physician or per your request. I voluntarily consent to the consultation/treatment at this practice. No guarantees have been made to me in regards to my outcome. I will agree to participate to the best of my ability and communicate with my provider in regards to my goals and objectives.

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for North Georgia Nutrition and Wellness. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also grant permission for this practice and its affiliates to obtain information from my physician and other medical professionals as it relates to my consultation/treatment.

AUTHORIZATION FOR DISCLOSURE

I authorize the release of information to the following including diagnosis, records, clinical documentation and claims information to the following: Information is not to be released to anyone

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

MESSAGES - Please circle appropriate answer

Messages may be left for me in regards to my care and appointments: Yes No
Please use: Home Phone Cell Phone Work Phone Email
You may leave a detailed message OR Please leave message to return call

LATE ARRIVALS / CANCELLATIONS POLICY

Please consider your scheduled appointments carefully as we require a 24-hour cancellation of scheduled appointments. Patients arriving more than 15 minutes after their scheduled appointment time may be asked to reschedule.

OFFICE FEES / COLLECTIONS

If you present a check with insufficient funds, or place a stop payment on an issued check you will be charged a $25.00 fee for processing. Any patient account sent to collections agency for delinquent payments will accure a 38% collection fee.

ASSIGNMENT OF BENEFITS

I understand that I am ultimately responsible for the charges incurred for my services by North Georgia Nutrition and Wellness, LLC.
I have read and understand the above and foregoing Informed Consent, Authorization for the Release of Medical Information, Authorization for Disclosure, Messages, Assignment of Benefits, and agree to the terms thereof.

_____
PATIENT NAME SIGNATURE OF PATIENT/GUARDIAN DATE

_____
WITNESS