ACU-HEALTH CENTER
CAROL RIDER, L. AC., M.T.O.M.
OFFICE POLICIES

CONSENT/ AUTHORIZATION TO TREAT

I authorize Carol Rider, L. Ac., to perform such examinations as are, in her opinion and within the scope of her licensure and training, necessary or advisable. The treatment/ procedure(s) and any associated risk have been explained to me and all my questions were fully answered. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained.

RELEASE OF MEDICAL RECORDS

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, my caretaker(s), and/or the provider, if any, who referred me. The Patient Privacy Notice is incorporated into this section.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I request that payment of benefits be made to the above-named provider on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to any insurance company, any third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services.

INSURANCE DIRECT BILLING POLICY

Carol Rider, L. Ac., and/or her agent is authorized to file claims on my behalf with my insurance carrier for all treatment provided. In the event that my insurance carrier does not pay for my treatment, I understand, I understand that I am responsible for all charges incurred. Should I default in this responsibility and it becomes necessary to refer this account for collection, I agree to pay all costs of such collection, including but not limited to, reasonable attorney fees, court costs, and interest as permitted by law.

MISSED APPOINTMENTS/ LATE CANCELLATIONS POLICY

I understand that appointments cancelled or rescheduled with less than 24 hours notice are subject to a $35.00 late cancel/no show fee.

SIGNED NAME: _____ DATE_____

PRINTED NAME: _____