Patient Information (Please print)

Name: ____ DOB: _________________ Sex: M / F

Address: ____

City: ____State: _________ Zip: _________________

Home Phone: ____Cell Phone: ___________________________

Email: ____

Patient Employer: ____ Occupation: ____________________________

Emergency Contact: _____________________________________ Relationship: ___________________________

Phone: ____

Authorization to Release Medical Information

X_______I hereby authorize this facility to release medical information (labs, EKGs, etc. to the follow individual(s):

Name: ___________________________________ Relationship: ________________________________

Name: ___________________________________ Relationship:_________________________________

X_______ I understand I may revoke this authorization to release medical information at any time upon written notice. I hereby agree to hold harmless, any person complying with this authorization request.

X_______ I authorize the release of any medical information necessary to process insurance claims. I further authorize the release of any pertinent medical records to any physician and/or facility to which I may be referred. I agree to allow Branches Weight Loss and Wellness providers to review my external medication and medical history.

X ______ I authorize Branches Weight Loss and Wellness to share my information, relevant to my treatment, within the organization, including Branches Counseling Center.

Informed Consent Regarding Electronic Communication

It may be useful to communicate by email or phone. Be aware that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate, there is a chance that a third party may be able to intercept these messages. Should you choose these types of communication to contact Branches Weight Loss and Wellness then it is understood that you are consenting to communicating by these means.

May we send you appointment reminders via text message? Y / N ...via email? Y / N

May we communicate with you by email? Y / N

May we talk to whoever answers the phone numbers you provided? Y / N

May we leave messages at the numbers you provided? Y / N

X_______ I understand and agree.

I hereby acknowledge that I was given the opportunity to read a copy of the ***Notice of Privacy Practices*** *of Branches Weight Loss and Wellness and understand I may request a copy at anytime.*

Patient Name (PRINT): ____

SIGNATURE: ____ **DATE:** _________________________

Consent for Treatment

As the patient, you have the right to be informed about your conditions and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment for any identified condition(s).

I request and authorize medical care as my provider may deem necessary or advisable. This care may include but is not limited to, routine diagnostics and laboratory procedures, administration of routine drugs, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and the other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plan of treatment with my provider and to ask and have answered to my satisfaction any questions and concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _________ (initial)

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Patient Name (PRINT): ____

SIGNATURE: ___________________________________ **DATE:** ___________________________

Payment Policy

We accept and bill insurance as a courtesy. Currently, we accept Blue Cross-Blue Shield, Aetna and Cigna. Please check with your insurance company to determine coverage. We do not guarantee coverage of our services by your insurance policy. You are responsible for any remaining balance not covered by your insurance. We also offer a reduced cost self-pay option. All copays and self-pay costs are expected in full at time of service in the form of cash, debit card, or credit card (or HSA card).

Insurance Information

Insurance company: _________________________ Subscriber's Name: ________________________________

Subscriber's DOB: ________ Group Number: ______________ Policy Number: _________________________

Please check one: Employer provided plan________ Personal Plan _________

Patient's relationship to subscriber: ___ self ___ spouse ___ child ___ other ______________

Pharmacy benefit: ____

Cancellation Policy
Failure to provide notice of cancellation of an appointment more than 24 hours ahead of appointment time may result in a charge of $30. If this occurs, the card on file will be charged.

Assistance Program
We do not want an inability to pay to prevent anyone from taking advantage of our services to improve your health so we offer financial assistance to anyone who requests it. The financial assistance is limited and is distributed on a first-come, first-served basis. Assistance funds may only be used for office visit fees and may not be used for medications, supplements, or other services. Please speak with the provider during your visit if you are interested in receiving financial assistance for your visit or if you are interested in donating to the Assistance fund so that more people may benefit from our services.

Patient Agreement
I authorize Branches Weight Loss and Wellness to charge my credit card provided for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I authorize assignment of insurance benefits to Branches Weight Loss and Wellness in the event my insurance is filled as a courtesy. I acknowledge and agree that I am financially responsible and will pay for any deductible or co-payment for all services and treatment provided to me, including any amount not paid by my insurance plan, to the extent legally permissible at the time of service. The above information that I have provided is correct to the best of my knowledge. I have read this form in its entirety and agree to the policies listed above.

Patient Name (PRINT): ____

Signature: ____ **Date:** _______________