



## **HIPAA Privacy Rule of Patient Authorization Agreement**

### **Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))**

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

### **Privacy Rule of Patient Consent Agreement**

#### **Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))**

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness:

Patient Name:

# Whole Self Wellness, LLC

## Statement of Patient Financial Responsibility and Consent to Treatment

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Whole Self Wellness appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Whole Self Wellness, for providing Primary Care/Weight Management/Health Coaching/Physical Therapy or other services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Whole Self Wellness, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

I may see full Financial Responsibility Document for more detailed information

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Co-Pay/Co-Insurance Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent for Treatment and Authorization to Release Information

I hereby authorize **Whole Self Wellness**, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize **Whole Self Wellness**, to release to appropriate agencies, any information acquired during my or the above-named patient's examination and treatment.

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to contact this office **2 business days** prior to canceling your appointment. If notice is not given according to the policy, a \$50 fee will be assessed and payable prior to any scheduled appointments.

I understand if I no show for two consecutive appointments, no show or cancel for three or more appointments within one year,, I may be discharged from care.

The Practice will notify you in writing, via mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Whole Self Wellness, LLC  
12 Case Street, Suite 103  
Norwich, CT 06360  
Phone: 860-222-0949  
Fax: 888-326-5828  
[www.wholeselfwellnessct.com](http://www.wholeselfwellnessct.com)



## **Whole Self Wellness Attendance Policy**

- If you are 10 minutes late for your appointment, this will be considered a no call/no show appointment and will be charted as a missed appointment.
- If you cancel less than 2 business days before appointment, this will be considered a no show, and you will be charged a fee of \$50, to be paid prior to your scheduled appointment.
- If you have three no show/late cancelations, you will be discharged from the practice. A referral list will be provided at the time of discharge.

Your Signature below indicates that you have read the above information and agree to the attendance policy as a patient at Whole Self Wellness, LLC.

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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## INFORMED CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. I understand that my health care providers, and I, will engage in a telemedicine visit for myself or my child.
2. I understand that this consultation will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions and possible technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that even though I am being seen remotely, I or my child may still need to be seen face to face. This will also be a separate visit and additional charge.
- 5 I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
6. I understand that my insurance (if applicable) will be billed for the telemedicine visit. I accept that I am financially responsible for any balances or if my insurance will not cover the visit.
7. I have read this document carefully and understand the risks and benefits of the teleconferencing consultation and I consent to participate in a telemedicine visit under the terms described herein.

\_\_\_\_\_  
Patient's/Parent/Guardian Signature

\_\_\_\_\_  
Date and Time



12 Case Street, Suite 103  
Norwich, CT 06360  
P:860.222.0969 F:888.326.5828

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize Whole Self Wellness to disclose or obtain health information, including if applicable information relating to the diagnosis or treatment of medical, mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Information may be:

- Disclosed to
- Obtained from other Facility

Name/Facility: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

- Hand-Carry
- Fax to: \_\_\_\_\_

The purpose of this disclosure or use is for the following reason:

- Medical
- Legal
- Disability
- Insurance
- At the request of the patient or legal representative
- Other: \_\_\_\_\_

The dates of service and the type(s) of information to be used or disclosed is as follows: \_\_\_\_\_

Choose what's applicable:

- Medical
- Physical Therapy
- Behavioral Health (other than psychotherapy notes)
- Complete Record Abstract Only Specific Report
- Requested Information:
  - Sexual/STD information
  - Substance abuse (Drug/Alcohol)
  - Confidential HIV/AIDS related information



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I understand that my treatment or continued treatment by Whole Self Wellness is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may inspect or request a copy of the information to be used or disclosed by the recipient.

This authorization will be valid for a period of one year from the signature date below. Medical Records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying Whole Self Wellness in writing. This will not have any effect on actions that the release took before the cancellation was received.

Copy Fees: I understand that Whole Self Wellness may charge a fee for copying and first class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut Statute at \$0.65 cents per page.

Signature of Patient or Legal Representative: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

If not patient, state the relationship to patient below

- Parent
- Guardian/Conservator
- Executor of Estate/Power of Attorney
- Other \_\_\_\_\_

NOTE: The confidentiality of psychiatric, alcohol, drug and HIV related records is required by Connecticut General Statutes and/or Federal Regulations 42CFR. part 2. This information shall not be re-disclosed to anyone else without written consent or other authorization as provided in the Connecticut General Statutes and/or Federal Regulation 42 CFR. part 2. A general authorization for the release of medical information is not sufficient for this purpose

# Permission to Verbally Discuss Protected Health Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Street Address: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

Work Phone Number (optional): \_\_\_\_\_

Check all boxes that apply:

- I give permission to Whole Self Wellness to leave a voicemail message for me at the Preferred Phone Number listed above.
- I give permission to Whole Self Wellness to VERBALLY discuss information about me with:

Check all boxes that apply:

- Scheduling / Appointment information
- Medical information, including my symptoms, diagnosis, medications and treatment plan
- Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- Billing and payment information
- Other: \_\_\_\_\_

I give permission to Whole Self Wellness to VERBALLY discuss information about me with:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Check all boxes that apply:

- Scheduling / Appointment information
- Medical information, including my symptoms, diagnosis, medications and treatment plan
- Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- Billing and payment information
- Other: \_\_\_\_\_

I have the right to change or revoke my permission in writing at any time except where Whole Self Wellness has already made disclosures in trust of this original request. **I understand that I must complete a new form or notify Whole Self Wellness in writing if I want to change or revoke any of the permissions indicated above.**

Signature of Patient/Authorized Representative

**(If authorized representative, please sign and attach copies of supporting legal documentation.)**

NOTE: To obtain copies of medical records, you will need to complete a **Whole Self Wellness Authorization to Release and Disclose Patient Information** form.