Amber Wellness Group (1/19)

By voluntarily signing this document, I show that I have been provided the clinic policies and consent to treatment. I have been told about the risks and benefits of naturopathic medicine and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I acknowledge that I received a copy of Amber Wellness Group clinic policies, as well as, HIPAA privacy laws.

I have filled out the insurance verification form and know that I am responsible for payment for any non-covered services.

I have fully read and understand the following:

HIPAA Notice of Privacy Practices
Financial Responsibility
Insurance Billing
Non-covered Services
Medicare and Medicaid
Roles and Responsibilities for Provider and Patient
General Information
Labs Review
Prescription Refill Policy
Supplements
Cancellation Policy
E-mail Policy
Patient Information

_____

Printed Name (if older than 18) or Parent/Guardian Name (if under 18)

_____ _____

Signature (I understand I many have a copy of policies to take home) Date

THIS SECTION IS TO BE COMPLETED BY AMBER WELLNESS GROUP, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because: [ ] Patient declined to sign this Written Acknowledgement [ ] Other (specify):