

Center for Holistic Medicine Patient Information

779 Haywood Road, Asheville, NC 28806

Name _____ Date _____

Street Address _____

City _____ State _____ Zip Code _____

Main Phone _____ Alternate Phone _____

E-mail _____

Date of Birth _____ Physician _____

Emergency Contact _____ Contact's Phone _____

How did you hear about us? _____

What condition are you seeking treatment for? _____

Center for Holistic Medicine Office Policies

1. Cancellations must be made within 24 hours of the scheduled appointment. There is a \$25 charge for missed appointments or appointments cancelled with less than 24 hours notice.
2. Unless other arrangements have been made, all fees are due at the time that services are rendered.
3. All payments for herbal medicine and other products are due when they are received.
4. Forms of payment accepted include cash, personal checks, Discover, Master Card, and VISA.
5. At this time we do not accept insurance but we are happy to provide you with the information that you need to do so on your own. Please see the section regarding health insurance on our website for information about Health Savings Accounts.
6. Please be on time for scheduled appointments. If you are late, please understand that the practitioner may not be able to see you.
7. There is a \$45 sur-charge for returned checks.
8. Please advise the Center of any changes in your personal information, especially your address and phone number.
9. We do accept walk-ins, but please understand that scheduled appointments take precedence.

Signature _____ Date _____

Center for Holistic Medicine Privacy Policy

779 Haywood Road, Asheville, NC 28806

The Center for Holistic Medicine may need to share limited personal medical and financial information with your insurance company, Worker's Compensation, your employer, or with other medical practitioners that you authorize. Information about our patients that we gather and use includes non-public personal information such as treatment notes, test results, medical history, and communications to or from other health care providers. We have safeguards at our office regarding storage and handling of all medical files. The following text outlines your rights as a patient regarding the personal information about you in our files.

I understand I have the right to review this policy prior to signing this document. The Privacy Policy describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of CHM. The Privacy Policy also describes my rights and the duties of my practitioners and CHM with respect to my identifiable health information.

My identifiable health information refers to my demographic information as collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my identifiable health information by the Center for Holistic Medicine (hereafter noted as CHM) for the purposes of diagnosis, treatment, payment, or health care operations. I understand that diagnosis or treatment of me at CHM may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. CHM is not required to agree to the restrictions that I may request. However, if CHM agrees to a restriction that I request, the restriction is binding upon CHM.

I have the right to revoke this consent, in writing, at any time except to the extent that CHM has taken action in reliance on this consent.

CHM reserves the right to change information contained in the Privacy Policy at any time.

Signature _____ Date _____