ACKNOWLEDGMENT AND CONSENT

I understand that Julie Foster, MSN, FNP will use and disclose health information about me. I Understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Julie Foster, MSN, FNP may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Julie Foster, MSN, FNP will handle health information about me. This written description is known as a Note of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Julie Foster FNP and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Julie Foster, MSN, FNP's Notice of Privacy Practices in effect will be posted in reception/waiting area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Julie Foster, FNP is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices and our Financial and Insurance Policies.

_____ _____

(Patient's signature or Patient's Representative (Date)

Description of Representative's Authority_____

Julie Foster, MSN, FNP may prescribe natural medications and Anthroposophical medications from this office to her patients. Motor Vehicle, Worker's Compensation and most regular health insurance carriers **DO NOT** cover the cost of these medications as they consider them over the counter medications.

All medications that are injected by Julie Foster will be billed to your insurance company and may or may not be covered. It is therefore the patient's responsibility to pay for these items at the time of service. In the event that your insurance policy does not cover these items the patient will be responsible for payment in full.

We require a 24 hour notice for canceling appointments. There is a $75 fee for all appointments not cancelled within 24 hours. This amount will not be billed to your insurance company. You will be billed and be responsible for this amount.

I have been advised that if my insurance company does not wish to cooperate in paying the practitioner, the practitioner will not await payment, but will require me to pay in full or arrange for payments on a monthly basis.

I understand that I am fully responsible for all charges associated with treatment that I receive from this office.

I understand that it is my responsibility for verification of insurance coverage and will be responsible for fees not covered or approved by insurance company.

☐ **Private pay / Self pay** – a $100 deposit is required at the first visit. Payment is due at time of service or special arrangements must be made in advance with this clinic.

_____ _____
Patient's or guardian's signature Date

☐ **Private health insurance** – Co-pays and deductibles are due at time of service. Patient is responsible for all deductibles, coinsurance, non-covered services, natural medications and items not medically necessary.

_____ _____
Patient's or guardian's signature Date

Special arrangements agreed upon by the clinic and patient are as follows:

_____

_____

_____ _____ _____ _____
Patient's or guardian's signature Date Clinic's signature Date