



838 Powdersville Rd | Suite G | Easley, SC 29642
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Office Policy Form

Patient Name: _____ Date of Birth: _____

Thank you for choosing us for your healthcare needs. We are here to help you with your health. The following is to assist you in understanding the LivingWell Integrative Healthcare policies. Please read them carefully, initial each section and sign after reading.

Initial _____ **Payment Requirements:** Appointments must be paid for at the time of service. We do not file insurance for our services. We accept Visa, MasterCard, America Express, Discover, Check and Cash. There is a \$35.00 charge for return checks. As a courtesy to you, we do submit your insurance to the laboratories for them to file insurance. Any discrepancies with your lab bill would need to be directed to the lab company.

Initial _____ **Appointments:** We require a 2-business day notice if you need to change or cancel your appointment. Patients not showing up for appointments or cancellations for less than 2 business days may be charged the total cost of any missed appointment.

Initial _____ **Records:** Your medical records are kept in an electronic medical record or paper chart form. Patients can be given a copy of their lab reports upon completion of your visit if they desire a copy. Additional copies of medical records can be released with a signed and dated authorization form provided to us. Please allow 10 business days for processing the request. There is a reasonable charge for a second copy request as outlined by state law.

Initial _____ **Insurance and Medicare/Medicaid:** LivingWell Integrative Healthcare DOES NOT file insurance claims or participate in insurance. None of our providers are "preferred providers" for any insurance program. We are NOT Medicare/Medicaid providers, and our services are NOT BILLABLE TO MEDICARE/MEDICAID AND MOST SUPPLEMENT INSURANCES. We can provide a receipt for a patient with commercial insurance to assist with reimbursement.

Initial _____ **Payment Options:** I understand that if I choose payment option of paid in full or draft payments, they are non-refundable. Copies of my signed agreement will be kept on file.

Initial

I understand that medical records can or may be faxed or e-mailed at the patients request with written, valid authorization or for continuity of care to other facilities. Medical records released via fax or e-mail may not be secure after release.

Initial

I understand that if given permission for release of records to LivingWell Integrative Healthcare, the permission can be withdrawn at any time. It does not affect the release of any previously released records as requested.

Initial

I understand if I choose to email my healthcare provider(s), the email is considered a convenience and is not appropriate for emergencies or time-sensitive issues. Sensitive or personal information should not be communicated via e-mail.

Patient Signature

Date