Keystone
NATURAL FAMILY MEDICINE

PATIENT RESPONSIBILITY STATEMENT

- **Scheduling ~** We value your time and strive to keep appointments at their set time. We encourage our patients to be responsible for their own health care, which includes scheduling. We do not overbook appointment times; your scheduled visit is dedicated to you. If you are late, you may be asked to reschedule. _____

- **Cancellation and missed appointment charges**:
  - New Patients- Significant time is scheduled with the doctor for new appointments, a 48 hr business day cancellation is required for all new patient appointments. New patient appointments that are cancelled without a 48 notice will be subject to a $100 cancellation fee.
  - Established Patients- Missed appointments with less than 24 hr business day notice may incur a $50 cancellation fee.
  - We maintain the privacy and security of your credit card information _____

- **Phone call policy ~** Keystone Natural Family Medicine doctors encourage patients to call the office during regular office hours (8:00 am to 4:00 pm) if you have questions after your office visit. Often, clarifying issues and answering basic questions can greatly enhance the success of your health care. Due to time constraints, however, phone calls longer than 5 minutes regarding existing treatments or conditions will be billed as a phone consultation. Phone calls of any length covering new symptoms will be billed as a phone consultation.
- Emergency phone calls to the doctor's cell phones after hours or on weekends and holidays may be subject to a $100 emergency contact fee. _____

- **Payment ~** Payment is due at the time of service. For your convenience we accept cash, check, Mastercard and Visa. There is a $35 fee for any returned checks. New patient visits are $295 for adult and $195 for children and follow-up visits $135

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- **Medicinary and Supplements ~** All items from the medicinary must be paid in full upon receipt. Unfortunately, there can be no refunds for products that have been opened or for custom formulations. _____

- **Additional Consent ~** From time to time we use photography, testimonials, and/or video for marketing purposes. Patients may be contacted using various methods including but not limited to email, social networking, text messages and phone calls. By initialing, you are giving your consent. _____

By signing below, I certify that I fully understand the above policies and consent to treatment.

Patient Name: _____

Signature: _____ Date: _____

10153 East Hampton Avenue ~ Suite 104 ~ Mesa, AZ 85209

HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I have been informed of the changes to HIPAA policy as of September 23, 2013

_____
Patient Name

_____
Signature

_____
Relationship to Patient
(If signed by someone other than patient)

_____
Date

10153 East Hampton Avenue ~ Suite 104 ~ Mesa, AZ 85209

10153 E Hampton Avenue, Suite #104
Mesa, AZ 85209
Phone 480-535-5688
Fax 480-535-5689

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

[ ] Spouse_____

Phone:_____ Email:_____

[ ] Child(ren)_____

Phone:_____ Email:_____

[ ] Other_____

Phone:_____ Email:_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____
Witness:_____ Date: ___/____/_____