OFFICE POLICY:

1. **INSURANCE**

   In network – benefits will be verified, and any copay or deductibles will be collected at the time of service. We will then submit claims to the insurance carrier on your behalf, and upon insurance determination, you will be billed for any amount deemed your responsibility by the carrier less any prepayment. **Out of networ**k –Some plans might have out of network benefits. Benefits will be verified, and your copay, deductible, and estimated responsibility after out of network benefits will be collected at the time of service. Non-HMO insurance companies with "out of network benefits" usually cover a portion of the office visit and lab testing charges. Each insurance company has different policies therefore reimbursement is not guaranteed. You are responsible for all bills even if your insurance company doesn't pay.

   ICON DOES NOT ACCEPT: **MEDICARE, TRICARE, CHAMPUS, MEDICAID, WORKER'S COMPENSATION, or CHIP. Patients presenting with these carriers are subject to self-pay rates which are due at time of service.**

   In the event that the insurance carrier inadvertently sends a check to you in payment of our services, you must forward it to our office immediately, or you may pay our office directly for insurance payments received by you.

2. **Medical Records** – Apart from routine copies of lab work, there is a cost for medical records, plus postage, if applicable. You must sign a medical release form and pay the copying fees before the records will be sent out.

3. **Medical questions** – should be addressed with the Doctor or medical staff only. Administrative staff cannot answer medical questions or give medical advice, but will be happy to pass any questions or concerns onto the medical staff.

4. **We reserve the right to immediately discharge a patient from our practice** if a patient is abusive to the staff or refuses to honor our office policies and/or medical protocol.

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

I understand that as a part of the provision of health care services, Icon Wellness Center, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices (given upon check in at front desk) that provides a complete description of the uses and disclosures of certain health information and identifiers such as my name, date of birth, insurance card and driver's license, telephone number and address. It also explains how I may AMEND my medical records, obtain a RECORD OF DISCLOSURE or FILE a COMPLANT regarding disclosure of my records. I understand that I have had the right to review the notice before signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations (quality assessment and improvement activities, underwriting, premium rating conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.
By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations, this includes calling me for an appointment reminder. I have the right to revoke this consent, in writing, except where disclosures have been made in reliance on my prior consent.

THIS CONSENT IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health operations, be restricted. I also understand that Icon Wellness Center and Medical Spa and I must:
   A. Agree to any restriction in writing that I request on the use and disclosure of my protected health information; and
   B. Agree to terminate any restrictions in writing on the use and disclosure of my protected health Information which have been previously agreed upon.

By signing below you acknowledge that you have read this document and agree to abide by our office and privacy notification policy.

_____/ _____ _____

Signature of Patient, Guarantor or Guardian Date Printed Name