FAL RIVER HEALTH CENTER, LLC

Integrative Medicine

Linda S. Grigel MHP, PA-C

NEW PATIENT DEMOGRAPHICS

First Name: _____ MI: _____ Last Name: _____

D.O.B: _____ Gender: _____ E-Mail: _____

Phone: (c) (_____) _____ (w) (_____) _____ (h) (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____

Phone: (_____) _____ Relation to patient: _____

***Patient Signature:** _____

Date: _____

IF PATIENT IS A MINOR

Parent /Guardian's Name: _____ Relation: _____

Phone: (c) (_____) _____ (w) (_____) _____ (h) (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____

***Guardian Signature:** _____

Date: _____

Fal River Health Center, LLC
5 Fundy Road, Suite 10B
Falmouth, ME 04105

Tel: 207-781-7880
Fax: 207-781-7882
www.falriverhealthcenter.com

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HIPAA AGREEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that **Fal River Health Center, LLC** has given you a copy of its Notice of Privacy Practices for your perusal (and a copy of the document if you so desire). This notice explains how your personal health information (PHI) will be handled. HIPAA, the new Federal law concerning medical privacy requires this notice.

By signing below, I agree that I have read a copy of the Notice of Privacy Practices, and that this office has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

IF PATIENT IS A MINOR

Parent / Guardian's Name (print): _____

Relation to Patient: _____

Parent / Guardian Signature: _____

Date: _____

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CANCELLATION POLICY

Effective January 1st, 2021

You and your family are very important to us. As an Integrative Medical practice we are dedicated to providing the highest competency of healthcare and education. We hope you understand the reason for this cancellation policy.

Follow-Up Appointments

24-hour notice is requested (not including weekends and/or holidays).
If a cancellation is not made, you will be charged 100% of the appointment fee, accounting for the amount of time reserved.

New Patient Consults

72-hour notice is requested (not including weekends and/or holidays).
If a cancellation is not made, you will be charged a $275.00 non-refundable fee. If you choose to reschedule, pre-payment for the allotted time will be requested, in addition to the cancellation fee.

We do understand that there are extenuating circumstances; a simple phone call is requested to avoid these charges. However, texts cannot be used for communication. SMS messaging is not HIPAA compliant and your personal health information (PHI) could be compromised.

By signing below, I understand and agree to the above policies.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

IF PATIENT IS A MINOR

Parent / Guardian's Name (print): _____

Relation to Patient: _____

Parent / Guardian Signature: _____

Date: _____

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CREDIT CARD AUTHORIZATION

I authorize **Fal River Health Center, LLC** to charge the agreed amount listed below to my credit card provider. I agree to pay for these purchases in full in accordance with the issuing bank cardholder agreement. Communication through calls is based on time needed for the response. My credit card will be charged accordingly.

I consent to: 15 minutes = $115; 20 minutes = $125; 30 minutes = $150; and 50 minutes = $180.
Prescription refills will be charged only for the amount of the supplement(s), shipping, and handling.

I understand it is my responsibility to provide updated credit card and Health Savings Account (HSA) information (account number, expiration, CSV) as needed. If an HSA is the primary card, an additional credit card will be required to charge for any remaining balance in the event of insufficient funds. Should the HSA or credit card be declined, a three (3) day grace period will be given prior to using the card a second time. If it is declined again, a $25 service fee will be added to the account balance.

I consent to payment being charged and/or withdrawn from my credit card as follows:

Patient Name: _____ Phone: (_____) _____

CREDIT CARD

Full Name on Credit Card: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Account Number: _____ Expiration MM/YY: _____ CSV Code: _____

By signing this Credit Card Authorization Form, I agree to allow my credit card to be charged as stated above and I attest that the information I have provided is accurate and truthful.

Cardholder Signature: _____ Date: _____

HEALTH SAVINGS ACCOUNT (HSA) CARD

Full Name on Credit Card: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Account Number: _____ Expiration MM/YY: _____ CSV Code: _____

By signing this Credit Card Authorization Form, I agree to allow my HSA account to be charged as stated above and I attest that the information I have provided is accurate and truthful.

Cardholder Signature: _____ Date: _____

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