



# AUTHENTIC HEALTH LLC

## HIPAA and General Policy Consent Form

### **Consent to Treatment:**

I hereby authorize Authentic Health to provide services in one or more of the following:

- Pediatric Occupational Therapy
- Nutrition Counseling
- Specialized Kinesiology
- Craniosacral Therapy

### **Informed Consent:**

I understand that practitioners of Occupational Therapy, Nutrition Counseling, Specialized Kinesiology, and Craniosacral Therapy do not diagnose illness, disease, or any other physical or mental disorder. As such, at Authentic Health LLC we do not prescribe medical treatment nor pharmaceuticals, nor perform psychological counseling. I further understand that it is my responsibility for alerting the therapist to any physical condition or prescribed medication that would impact the work being done. All client information will be held in strict confidence in accordance with HIPAA.

### **Consent to Financial Policy:**

I understand that I am required to pay at the time I make my appointment online unless otherwise arranged directly by contacting Authentic Health LLC. If I arrange to pay in person, I understand that my payment will be due at the beginning of the appointment. Authentic Health LLC accepts cash, personal check, and credit cards.

I understand that a returned check is subject to an additional \$35 fee. If this happens, future payments must be made in cash or with a credit card. I understand that should it become necessary for Authentic Health LLC to enlist a collection service and/or legal assistance I will be responsible for any collection and/or legal charges up to 35%.

I understand that if I cancel a session with less than 24-hours' notice will be charged a cancellation fee of \$50.00. If I cancel an appointment with more than 24 hours' notice, no fee will be charged.

If I arrive late for a session, I understand I be charged for the full scheduled session fee shown online for the service. I understand that a scheduled appointment for which no cancellation has been made (no show), I will be charged for the full fee for the session.

### **Consent to Insurance Policy:**

I understand that Authentic Health LLC does not process insurance but will provide me with diagnostic and treatment codes along with progress notes, so that I may personally bill my insurance company for reimbursement. Some services are not available for reimbursement, and it is my responsibility to check with my insurance company.

I understand that if I am submitting for reimbursement to my insurance company that the fee for missed appointments will not be covered. I understand that scheduled appointment times are for



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client treatment and education. In depth consultation beyond treatment and education may be arranged by ending a treatment session early or by scheduling a separate consultation meeting. I understand that these meetings are charged at the provider's regular rate but may not be covered by my insurance company if I submit for reimbursement.

### **Consent to HIPAA Policy:**

Authentic Health LLC collect data through a variety of means including but not necessarily limited to name, contact information, medical history and current condition, in order to process treatment with our organization.

### *What We Do Not Do with Your Information:*

Information about your medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

### *How We Do Use Your Information:*

Information is only used as is reasonably necessary to process your application or to provide you with health services which may require communication between Authentic Health LLC and health care providers, and medical product or service providers necessary to: verify your medical information is accurate; or to determine the type of medical supplies or any health care services you need.

*Information We Do Not Collect:* We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page ([www.authentichealth78.com](http://www.authentichealth78.com)) that simply records the number of visitors and no other data. We may offer links to other sites that may or may not capture traffic data through our site. To avoid potential data capture, simply do not click on any of our outside links.

*Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:* We may request to have you provide a testimony to the success of the work done. If we do and you agree, you acknowledge that any notes sent to us, may be used in a non-identifying manner for promotional purposes.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.



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You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent. The HIPAA policy above is also provided after signature as a handout.

### Consent to Email Communication Policy:

I give permission for Authentic Health LLC to communicate with me by phone, text and/or email to discuss evaluation results, discuss treatment plans and progress, and to discuss other relevant information.

I specifically give permission for Authentic Health LLC to send appointment reminders, communications, therapy notes and invoices for services rendered via email and attachments. I am aware that there are inherent risks to confidentiality when email is used, and that email communications can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. I may choose to request that all reports be handed directly to me, and it is my responsibility to specify this with my provider at the first time of service.

I have read, and consent (agree) to all the policies stated above. I fully acknowledge this agreement with my signature and witnessed by the name and signature below.

This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This consent witnessed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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## AUTHENTIC HEALTH LLC

### Release of Personal Information Authorization

By signing this form, I authorize Authentic Health LLC to release and/or discuss confidential health information about me with the other health care practitioners or entities involved in my case, as listed below:

Practitioner/Entity and phone contact or email (to include doctors, other therapists, schools, etc.):

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\_\_\_\_\_  
Printed name of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date