Laurie Arndorfer, MD

New Hope Psychiatry for Women, PLLC

360.255.2505 Ext. 121

Dear ___________________________,

Welcome to my practice! I am pleased that you have selected me as your provider, and look forward to meeting you at our first appointment:

Date: ________________________________ **Time:** ___________________________

Your appointment will be at 801 Samish Way, Bellingham, WA 98229

Please ring the doorbell to the left of the reception window about 10 minutes before your first appointment to turn in these forms, as well as your insurance card(s), photo ID and any payment to my staff.

<u>Enclosed you will find:</u>

- **Intake form** – Please fully complete both sides.
- **My Provider Profile** – including a brief description of me.
- **Terms of Service/Disclosure Statement** – Two forms are included. Please read and return one signed form to me; the other is for you to keep for your records (required by Washington State law).
- **Notice of Privacy Practices** – Please read this form and keep it for your records (required by Federal law).
- **Other:** ____

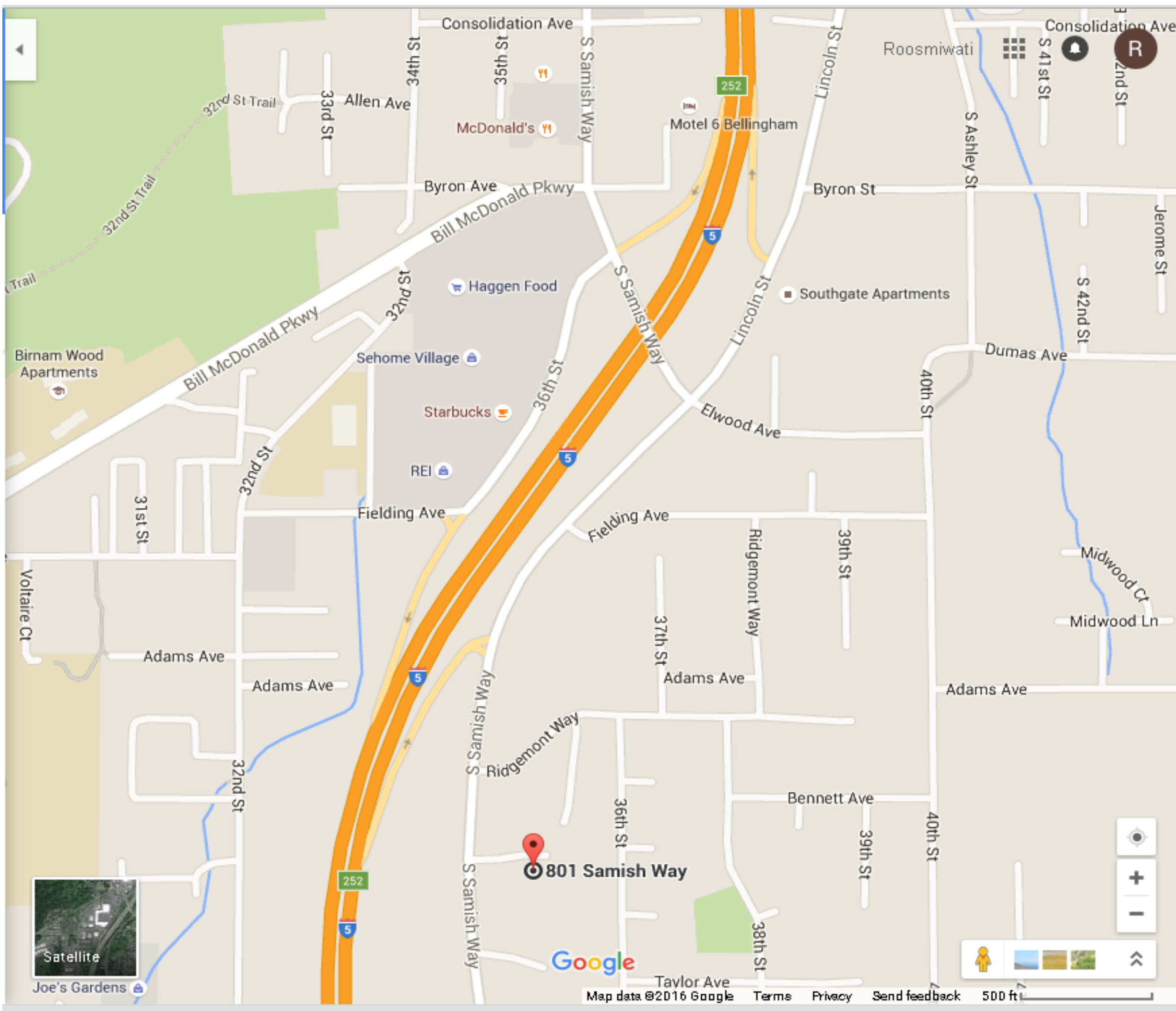
Thank you for carefully reading and completing these forms. Please bring them with you to our first appointment, as well as your insurance card(s) and photo ID.

If, after reading these forms, you decide against entering a therapeutic relationship with me, I ask only that you contact me as soon as possible and no later than 48 hours prior to our scheduled appointment time.

Otherwise, I will see you at our first appointment. Directions to my office are on the back of this letter.

Sincerely,

Laurie Arndorfer, MD



Directions are as follows:

From I-5 North

1. Take the Samish Way exit, EXIT 252, toward W Wash University.
2. Turn sharp right onto Samish Way.
3. 801 Samish Way is on the left just past Ridgemont Way.

From I-5 South

1. Take the Samish Way EXIT 252.
2. At traffic light, turn left onto So. Samish Way,
3. Then right turn at the next traffic light onto Samish Way.
4. 801 Samish Way is on the left just past Ridgemont Way.

Laura Arndorfer, MD

New Hope Psychiatry for Women

CLIENT INTAKE FORM

PLEASE FILL OUT COMPLETELY

Patient Name: ______________________________ Social Security #: _______xxx-xx______________
Mailing Address: ____
City/State/Zip____

Picture ID Copied ☐ Verified ☐

Home Phone #________________ Work Phone #______________ Cell Phone # ______________

OK to leave message? YES/NO *YES/NO* *YES/NO*

Date of Birth: _________________ Referred by: ___________________________________
Sex: FEMALE / MALE Primary Care/Obstetric Physician: __________________________
Employer / School_________________________________ Position/Grade____________________
Employer Address____
Emergency contact___________________________ Phone # ____________________________

PRIMARY INSURANCE

Insurance Co.: ________________________
Policy ID Number: ____________________
(*this may be a social security #)*
Group Number: ______________________
Policy Holder's Name:
____
Relationship to you: __________________
Policy Holder date of birth: _____________

SECONDARY INSURANCE

Insurance Co.: ______________________
Policy ID Number: _______________________
(this may be a social security #)
Group Number: _________________________
Policy Holder's Name:
____
Relationship to you: _____________________
Policy Holder date of birth: _________________

PERSON RESPONSIBLE FOR PAYMENT:

Name: ___________________________________ Relationship to patient: ____________________
Date of Birth: ____________________ Drivers License #: ________________________
Mailing Address: ____
Social Security number: ____________________ Home Phone: _______________________
Employer: ____________________________________Position______________________________
Work Phone: _______________________

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS / CONTRACT

I hereby authorize Dr. Laura Arndorfer to release to my insurance companies any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to Dr. Laura Arndorfer. I acknowledge that I have read or been offered the enclosed Notice of Privacy Practices. I certify that all the above information is correct and I have read and will subscribe to the payment policy on my practitioner's disclosure form.

_______________________________________ ______________________________
Signature Date

Version w0819

Laura Arndorfer MD
New Hope Psychiatry for Women
INTAKE INFORMATION

PERSONAL INFORMATION

Where were you born/raised? ______________________________

Educational Level (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

FAMILY SITUATION

RELATIONSHIP STATUS: single involved engaged cohabitating
married separated divorced widowed

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

Partner/Spouse	Beginning Year	Ending Year	Names/ages of children from relationship	Where/with whom do they live?

Others living in your home, ages, relationship: ______________________________

____

Your sources of social/emotional support (family, friends, spiritual community, etc.):

____

____

Current sources of income (circle all that apply)

Employment Retirement Disability Family Savings/Investments Other: ____________

EMPLOYMENT: (circle all that apply)

Full time Part Time Current Occupation: ______________________________

Retired Disabled Student Homemaker

Past Occupations: ______________________________

Are you currently practicing a religion / faith system? ______________________________

What, if any, religious / faith traditions were important in your upbringing? ____________

____

MEDICAL HISTORY

LIST ALL PREVIOUS AND CURRENT ***PSYCHIATRIC*** MEDICATIONS:

Drug Name	Strength	Times/Day	Approximate start/end date	Results

ALL ***OTHER*** CURRENT MEDICATIONS (Including vitamins, herbal supplements and over-the-counter drugs):

Medication	Dosage	For What Purpose?	Date Started

Please list all current health care providers: ____

____

____

Current medical (non-psychiatric) illnesses, problems, issues. Please be as complete as possible:

____

____

____

Previous medical illnesses, problems, and surgeries (include dates):

____

____

____

Allergies to medicines: ____

Alcohol/Drug/Tobacco/Caffeine use:

Past: ____

Present: ____

MENTAL HEALTH HISTORY

Have you had mental health problems in the past (please explain)? ________________________________

____

____

Have you sought treatment for this or other mental health problems? Was it helpful? ________________

____

Were you ever hospitalized for psychiatric reasons? If so, when and where?

____

Have any of your relatives had problems with their mental health? If so, please describe: _____________

____

GOALS FOR TREATMENT

What would you like to see happen as a result of your work here? _________________________________

____

____

____

_____________________________________ _____________________________________

Signed (Patient signature) Date

SECTION BELOW IS FOR OFFICE USE ONLY

Laurie Arndorfer, MD

Psychiatrist

New Hope Psychiatry for Women, PLLC
801 Samish Way, Bellingham, WA 98229
360.255.2505 Ext. 121

TERMS OF SERVICE / DISCLOSURE STATEMENT

I am pleased that you have chosen to work with me for your psychiatric care. I intend to have our time together be a helpful and positive experience for you. I believe clear and direct communication is an important part of this goal. This document is designed to ensure that you understand our professional relationship.
Please read it carefully and ask if you have any questions.

CONFIDENTIALITY AND PRIVACY:

As your psychiatrist, I will keep confidential anything you say to me, with a few exceptions as required by law to protect your safety or the safety of others.

I am part of a clinical consultation group which meets to facilitate good care. While I may discuss your case with this group, I will not disclose your identifying information.

A copy of the Notice of Privacy Practices is provided in your packet. If you have any questions about this policy, you can discuss them with me or our Hipaa Privacy Officer in the billing office.

FEES AND PAYMENT:

My rate for psychiatric treatment, including evaluation, medication management and/or psychotherapy is $90 for a 15-minute session, $170 for a 30-minute session, $250 per 45-minute session and $ 350 for initial assessment. Phone calls greater than 5 minutes will be billed at $5 per minute. Preparation and review of medical records will be billed at $50 each. Psychotherapy, consultation, training services, and court attendance may be billed at different rates and in accordance with our contracts with your insurance company.

I will bill your insurance company for our sessions and will collect the copay/coinsurance and or deductible amounts due from you in full at the beginning of each session. I may be paid by the insurance company for covered services. You are responsible for determining the specifics of your insurance coverage, as well as procuring relevant paperwork such as physician referrals, as your insurer may require.

Please note that as the recipient of services, you are responsible for all charges not paid by your insurance company. Payments will be due at the time the insurance company notifies us of any unpaid portion. Account balances which have been billed to you and remain unpaid beyond 90 days may result in referral to an outside collections agency and termination of treatment.

All insurance companies require that I diagnose your mental condition before they agree to pay for services. If you ask, I will inform you of the diagnosis I plan to render before I submit it to your insurance carrier.

PRESCRIPTION REFILLS:

Please have your pharmacy fax 360-255-2504 for all prescription refills. Allow 48 – 72 hours for a response to be sent to your pharmacy, so you should time your requests before you have run out of the current prescription. I have covering physicians when I am out of town and my staff will get this to the appropriate covering physician.

CANCELLATIONS:
In the event that you are unable to keep an appointment, you must notify me **48 hours in advance** (unless there is a reasonable emergency). If I do not receive such notice, **you will be responsible for paying the full fee for the missed session. Your insurance company will not pay for missed sessions.**

If you need to cancel or reschedule you can leave a message on my voice mail at **(360) 255-2505, Ext. 121**. Also, please remember to leave your home and work phone numbers with every message so that I can get back to you even if I am not in the office.

OUR RELATIONSHIP:
Although you may at times feel very close to me, it is important for you to realize we have a professional relationship rather than a personal one. Professional ethics require that our contact be limited to the paid sessions you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way other than in the professional context of our treatment sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns.

PHONE & EMAIL CONTACT:
Please do not use Email as a form of contact. I check it sporadically and it is not confidential. If you need to reach me between sessions during normal working hours, 8-5, Monday-Thursday, I can be reached by phone at **(360) 255-2505, Ext. 121.** Typically, you will get voice mail, which I check at least by 5pm each business day, and I will return your call within 24-48 hours during my regular business hours. Calls are not returned evenings, weekends or holidays except in the event of a true emergency. I would like to keep phone conversations as brief as possible, as it is normally not an appropriate method of conducting treatment. If a contact of more than 5 minutes is necessary during normal business hours, you may be charged at my usual hourly rate.

EMERGENCIES:
If you feel the need for emergency help, Pacific Harbor also has an answering service **(360) 714-6520** which will make every attempt to contact me. If I am unavailable, you are encouraged to call the **Crisis Line (staffed by professional therapists) at 1-800-584-3578.** My charges for emergency services include $200/hour prorated based on time spent. Please note that typically insurances companies do not pay for phone services, so you will be responsible directly for these charges. In the case of life threatening emergency, please call **911**, or go to the **Emergency Room**. Please note that repeated use of emergency services usually suggests that outpatient care is insufficient and alternative treatment will need to be discussed (i.e., hospitalization).

RELATIONSHIP TO PACIFIC HARBOR:
I am an independent private practitioner, though I have associations in other agencies. I operate out of Pacific Harbor Offices and have an agreement with Pacific Office Association, LLC, which provides administrative services. The associates, staff or practitioners in these facilities have no supervisory relationship or responsibility for my services in any way. All treatment decisions remain with you and me, as the psychiatrist and patient.

COMPLAINTS:
If at any time, for any reason, you are dissatisfied with my services, please let me know. If I am not able to resolve your concern, you may report your complaint to Dept. of Health, Health Professions Quality Assurance Division, P.O. Box 47869, Olympia WA 98504, or call (360) 236-4902.

___________________________________ ___________________________________

Patient Signature Dated Provider Signature Dated

Laurie Arndorfer, MD

Psychiatrist

New Hope Psychiatry for Women, PLLC
801 Samish Way, Bellingham, WA 98229
360.255.2505 Ext. 121

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If at any time, for any reason, you are dissatisfied with my services, please let me know. If I am not able to resolve your concern, you may report your complaint to Dept. of Health, Health Professions Quality Assurance Division, P.O. Box 47869, Olympia WA 98504, or call (360) 236-4902.

____________________________________ ____________________________________
Patient Signature Dated Provider Signature Dated

Vital Information about Your Mental Health Insurance

As your provider, my office will file a claim with your insurance company to help you receive any mental health insurance benefits to which you are entitled. Benefit plans can vary from company to company and can even change within the same company over time. Thus, it is important for you to investigate benefits by calling your insurance company *before your first scheduled visit*. Insurance companies often base the amounts that they will pay toward your treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay me a set allowed amount for each visit, regardless of what my customary fee may be. There may be set limitations in terms of a maximum number of visits to a mental health provider per calendar year. Deductibles and co-payments are typically built into most plans and state law strictly regulates their required payment. Both my office, and you as the policy beneficiary, can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its' restrictions, and my office will do our best to help you with maximizing your benefits.

<u>My responsibilities to you include</u>:

1. Complete your insurance claim forms and submit them to your carrier.
2. Accept any direct payment from your carrier and keep track of balances.
3. Notify you with a monthly billing statement of any remaining balances that may be your responsibility to pay.
4. My office will help to facilitate claims payment, but we do not have the ability to make your plan pay.

<u>Your responsibilities to my office include</u>:

1. To know your benefits.
2. To provide my office with up-to-date and necessary information concerning your insurance coverage so that we may correctly file a claim at the time of your first visit and at any time changes to your insurance coverage occur.
3. To pay any account balance promptly, including but not limited to, copays, co-insurance, and deductibles not paid by insurance. *Balances not paid by you in a timely manner may be referred to an outside collections company.*
4. Some insurance companies pay their benefits to subscribers rather than the provider. If you are paid by your insurance company for any benefits, we ask that you notify the office so that we can make necessary adjustments and correctly bill you for the amount due.

Thank you for choosing my office to provide your care. Please sign this form below acknowledging the responsibilities listed above. My office will keep one copy in your chart and will give you one copy for your own records.

______________________________ ________________

Patient or Insured's Signature Date

NEW HOPE PSYCHIATRY FOR WOMEN, PLLC

Contract for Payment of Services on Balances Over 60 Days Past Due

I understand that it is my responsibility to pay my balance in a timely manner, as specified on my providers disclosure. It is usual practice, and preferable, to provide payment for the session (self-pay, insurance co-pay, deductible, co-insurance) at the start of each session by cash, check, credit card, HSA or FSA card. I agree for New Hope Psychiatry for Women, PLLC, to keep my credit card details on file and understand that if I do not make arrangements with my provider, the amount I owe on my account that is more than 60 days past due will automatically be charged to my credit card. By signing this, I agree to authorize any such payments. I understand that it is my responsibility to keep my credit card information up to date. If there is a card denial, a $40 fee will be assessed.

I also understand that should my account balance remain outstanding, New Hope Psychiatry for Women, PLLC, does utilize the services of a collection agency, and I agree that New Hope Psychiatry for Women, PLLC, may release my name and contact information to any necessary party in the course of obtaining payment.

HSA/FSA cards are for medical treatment only (i.e. cannot be billed for missed appointments, reports or other non-medical treatment). These payment types are accepted for normal payments but a credit card must be kept on file as a back up payment or in the event the HSA/FSA or primary card account doesn't have enough funds.

Circle the following credit card type that will be kept on file to pay outstanding amounts owed over 60 days past due. Please stop in at our reception office for my staff to enter your card(s) on file:

PRIMARY CARD

HSA/FSA **Visa** **Mastercard** **Discover** **American Express**

Last 4 of Card Number:_________ Expiration:________________ Security Code (CVV):________

Name as it appears on the card:_____________________________ Billing Zip Code:_____________

BACK UP CARD (if HSA/FSA is primary)

Visa **Mastercard** **Discover** **American Express**

Last 4 of Card Number:_________ Expiration:________________ Security Code (CVV):________

Name as it appears on the card:_____________________________ Billing Zip Code:_____________

I authorize New Hope Northwest Psychiatry for Women, PLLC, to charge my account for any outstanding amounts owed over 60 days past due.

Cardholder Signature:____

Patient name: ___________________________________

Receipt email address: ____

I/we acknowledge understanding of and agree to the terms of this contract for payment of service.

Client(s) Signature:____

Date:_______________________________

Notice of Privacy Practices Regarding Protected Health Information

To our clients: *We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your ***Protected Health Information (PHI)*** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By signing this form, you are giving consent for us to disclose your PHI to other Pacific Harbor Psychology, Psychiatry and Psychotherapy therapists and/or other outside entities for the following purposes:

- ***Treatment:*** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.

- ***Payment*****:** obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

- ***Health Care Operations*****:** activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

II. Uses and Disclosures Requiring Authorization

Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an ***Authorization Form*** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your Psychotherapy Notes—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

We do not release your private health information for marketing or as part of a sale of information. (In situations where that do happen, your authorization would be required.)

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to believe that a child has been abused or neglected, she/he is required by law to report it to the proper law enforcement authorities.

- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that a vulnerable adult has been abandoned, abused, financially exploited, sexually or physically assaulted or neglected, she/he must immediately report it to the appropriate authorities.
- **Health Oversight:** If the State Department of Health subpoenas your therapist or your PHI as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This does not apply when you are being evaluated for a third party or for the court.)

- **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** If we are treating you under a worker's compensation claim, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

IV. Patient's Rights

- ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

- ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed.

- ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.

- ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

- ***Right to opt out of receiving fundraising communications.***

- ***Right to restrict disclosure*** of your private health information to a health plan when you have paid out of pocket, privately, for the health service.

- ***Right to be notified*** if there has been a breach of your protected health information.

V. Provider's Duties

- We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

VI. Complaints

If you have a complaint about the way we have handled your privacy rights, you may contact our Privacy Officer, 801 Samish Way, Bellingham, WA 98229, 360-255-2505 x100.

You may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services. 200 Independence Avenue, S.W., Washington, DC 20201 (877) 696-6775.

Communications and Credit Card policy

Contacting Me

When you need to contact your provider for any reason, these are the most secure methods to get in touch in a reasonable amount of time.

- By phone. You may leave messages in my voicemail, which is secure/confidential.
- Through our answering service (for emergency calls that cannot wait until the next business day).

Clinically, I will only use phone to communicate with you. It is important that we be able to communicate and also keep the confidentiality that is vital to our work together.

Response Time

I may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response during my business hours (weekends are excepted from this timeframe). I may occasionally reply more quickly than business hours; or on weekends, but please be aware that this will not always be possible.

Be aware that there may be times when I am unable to receive or respond to voicemails, and I may not always be available through the answering service (such as when out of cellular range or out of town).

Email or SMS messaging (text)

I do not use email or texting to communicate with patients for any reason, however our credit card payment system and appointment reminder system may offer these options to you.

Please know that any use electronic communications methods, whether secure or non-secure, such as email, texting, online video and possibly other methods, involves various technicians and administrators who maintain these services and may have access to the content of those communications. These accesses are more likely in some cases, than in others and are out of my control.

Of special consideration are work email addresses. If you use your work email for appointment reminders and/or credit card receipts, your employer may access those email communications. There may be similar issues involved in school email or other email accounts associated with organizations you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages our appointment reminder or credit card systems may have sent you.

Credit Card Payments

We are now using Square to process our credit/debit or HSA card transactions. For your convenience, you may pay the fees owed to your practitioner using your credit, debit or HSA via the following methods.

- With your card present in our office
- Online web payment through our website, pacificharbor.org
- Phone call to our staff
- Stored credit cards (for those with payment plans)

Please be aware of the following:

We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using Square to pay your fees, you may choose to have that service send you receipts for payment by email or text message. These receipts will indicate our business name, Pacific Office Association and would indicate that you have made a payment, listing your practitioner's name. You may ask us to print a receipt if you do not wish an electronic one.

Before paying by card for your session(s), please think about these questions and take any necessary steps to resolve issues, such as:

- At which email address or phone number have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
- Does the card belong to a spouse, parent or other family member and if so, what email address or phone number will those receipts go to? Would you have an issue if the card owner saw your receipt?
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to ***Pacific Office Association***. Please consider who might have access to your statements before making payments by credit card.

REQUEST FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, ________________________________ AUTHORIZE: ______________________________
(name of client) (name of practitioner)

____
(email address, if opted for)

____
(cell phone #, if opted for)

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY MENTAL HEALTH TREAMENT/PAYMENT:

☐ Text messages related to appointment reminders only
☐ Credit card payment receipts by text or email

TERMINATION

This authorization will terminate once all appointments and all patient balances have been paid in full.

I have been informed of the risks, including but not limited to, the confidentiality of my treatment, and/or transmission of my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment or make payments to my practitioner. I also understand that I may terminate this authorization at any time.

OPT OUT

☐ I choose not to receive texts for appointment reminders or texts/emails for credit payments (we need your help to remember when paying by card to ask for no receipt or a printed receipt can be done for you.)

I understand that my practitioner (named above) makes available to me the **following means of communication or payment that are secure and maintain confidentiality** and other alternate options for paying my outstanding balances, and I still choose to request and authorize the above-named non-secure means:

- **Communicate by phone or our secure voicemail only**
- **Payments can be made with cash or check only**

____________________________________ ________________________________
(signature of client) (date of agreement)

FOR OFFICE USE ONLY

	Square
	Appt reminders
	Medisoft
	List