Vibrance Internal Medicine

CONSENT FOR TREATMENT/DISCLOSURE & PAYMENT AGREEMENT

Patient's name_____ **Medical Record #:**_____

(1)Thank you for choosing us as your healthcare providers. We feel strongly that all patients deserve the very best medical care available and we are honored to be able to provide it. Please consent to be evaluated for medical treatment by the health care provider(s) of Vibrance Internal Medicine. _____**initial** _____**date**

(2)Disclosure- I have been offered a copy of the Notice of Privacy Practices and/or had it explained to me. I understand this notice and have had the chance to ask questions about any matters I don't understand. _____**initial** _____**date**

(3) Payment- I agree, in consideration of the services being rendered to me, I am hereby individually obligated to pay my account with Vibrance Internal Medicine in accordance with its regular rates and terms. If, signing as a representative, a parent or guardian, or otherwise legally responsible person for the patient, I agree to the obligation described herein. Payment of all co-pays, deductibles, coinsurance, and other amount not covered by insurance is due at the time of service.

Patients without insurance coverage: Payment in full is expected at the time of your first visit. Payment plan is available for follow up appointments.
_____**initial** _____**date**

(4) Missed Appointments: If you are unable to keep an appointment with our practice, please notify us at least 24 hours in advance of your appointment. failure to do so may result in a $50.00 charge for 15 minutes appointment and $75.00 charge for physical to your account. All missed appointment fees must be paid prior to your next visit. Exceptions may apply!

Payment Options: We accept cash, Visa, Master Card, and Care Credit only. We do not accept personal checks. _____**initial** _____**date**

(5) I consent for Vibrance Internal Medicine to communicate with my emergency contact,
_____**(name)**_____**(relationship),**
_____**(phone) regarding my health information and payment related to my care.**

I have read and understand the consent for treatment, disclosure, and payment agreement of this office and agree to abide this policy.

_____ _____
Patient/Responsible Party **Date**

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement; however, acknowledgement was not obtained because_____

Staff Signature:_____ Date:_____