Patient Consent Forms

Notice of Privacy Practices and Financial Disclosure

Acknowledgement of Receipt

I, _________________________________, hereby acknowledge that I have received a copy a detailed copy of the company's Privacy Practices Notice.

Patient / Guarantor Signature: ____ Date: _____/______/______
*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Consent to Release Information:

In the event I cannot be reached, I, ____________________________, give permission for a representative from Concierge Medicine of Columbus, Elite Family Medicine and Dr. Susan Westerlund's office , to speak with a family member(s) or companion(s) listed below regarding careor tests results.

Name: ______________________________ Phone: (____) ______-_______ Relationship:_________________

Name: ______________________________ Phone: (____) ______-_______ Relationship:_________________

Financial Disclosure:

__________ I understand that I am responsible for all co-payments, coinsurance amounts and deductibles. All co-payments, coinsurance amounts and deductibles are due at time of service. Additional payment may be required based on your individual insurance plan.

No Show Policy and Procedure

Initial below:

___________In the event you are unable to keep your appointment, please reschedule at least 24 hours in advance. Failure to notify our office within 24 hrs may result in a no-show fee of $45.00 for primary care and $50.00 fee for specialist.

___________ A $54 fee will be incurred for returned checks.

After Hours Telephone Advice

__________If treatment is rendered through the telephone evaluation and management, you may be billed for services rendered. These calls could be in reference to medcial advice and/or treatment given over the phone. The fee for this service can range from $20.00-$45.00. This fee is not reimburseable by insurance.

By signing below, I indicate my understanding of the above clinic policy and procedures.

Patient/Guarantor Signature: _______________________________ Date: _______/_______/_______
*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.