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

_____ Calls received office after hours in reference to medical advice and/or treatment given over the phone will be charged a fee from $25.00-$45.00.

_____ If you call the office during regular office hours and you are treated over the phone you may be charged for these services. Charges can range from $25.00-$50.00.
This fee is not reimburseable by insurance.

_____ If patients have forms to be completed, there will be a charge. Charges can range from $25.00 to $50.00 depending on the type of medical form.
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.