NEW PATIENT INFORMATION and CONSENT FORM

Osteopathic Wellness
253 Main St.
Yarmouth, ME 04096
Phone: 207-615-6956
Fax: 207-850-2228

PLEASE PRINT CLEARLY:

Patient's name_____ M___ F___ Transgender___ Birthdate_____

Patient's address _____

Email (**Print clearly**): _____

Telephones: home_____ work_____ cell_____

Social: Single___ Married___ Other___ Children _____

Occupation: _____

Patient's employer: _____

Patient's Primary Care Physician: _____

Emergency Contact Info: Name: _____ Relationship: _____ Phone: _____

I consent to receive text and/or email notifications reminding me of my appointments: Yes No

I, _____, understand and agree to the following:

I understand that payment for services by this office is solely my responsibility, regardless of any insurance coverage I may have. I authorize the release of any medical or other information necessary to obtain payment for services, or a release of records to medical review agencies as required by law. I voluntarily and knowingly consent to and request any type of outpatient treatment, which may encompass diagnostic tests and medical treatments deemed appropriate by the treating physician. I understand that such services are to be performed by the attending physician or by assistants designated by said doctor. I further authorize and consent to assistants and other personnel, to undertake this service and care as indicated by my attending physician.

I accept full financial responsibility for missed appointments for which I give less than 24 hours notice ("no show"), for any reason. I voluntarily and knowingly authorize The Practice (Osteopathic Wellness, LLC) to charge any credit card that I have on file with this office for immediate payment in full for such charges. I understand that upon the third "no show" I may be discharged from The Practice at the doctor's discretion, and that any prescriptions or certifications that I have through this office will be terminated along with my dismissal from The Practice.

I understand that Osteopathic Wellness/Shawn Marie Higgins, D.O. is not a Primary Care Provider (PCP) and that my visit with said doctor is for specialty services only as specified by The Practice.

_____ _____

Signature of patient, parent or guardian **Date**

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Osteopathic Wellness, L.L.C.
224 East Main St, Suite 1
Yarmouth, ME 04096

I am a patient of Osteopathic Wellness. I hereby acknowledge receipt of Osteopathic Wellness's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____ Date: _____

OR

I am a parent or legal guardian of _____ [patient name].
I hereby acknowledge receipt of Osteopathic Wellness's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: _____ Parent_____ Legal Guardian

Signature: _____ Date: _____

Authorization of Communication Via Email

I _____ authorize Osteopathic Wellness, LLC (The Practice) and its employees to communicate with me via email for the purpose of confirming appointments and for sending receipts for payment of any services rendered at The Practice. I understand that email is not a secure method of communication and that I have the choice to either accept or not accept an emailed receipt after every payment transaction. I understand that I may opt out of emailed appointment reminders and other forms of emailed communication of any kind at my discretion by informing The Practice in writing.

_____ Date: _____
Signature

No Show and Short Cancellation Policy

Osteopathic Wellness, LLC
253 Main St.
Yarmouth Maine, 04096

I, _____, understand that I am required to give at least 24 hours' notice prior to making a schedule change of any kind.

I understand that there is a first time no show or short cancellation fee of $50.00. After that I understand that for any subsequent no shows or short cancellations I am fully responsible for the FULL out of pocket price of my appointment.

I authorize Osteopathic Wellness, LLC to charge any credit card I have on file for immediate payment of these charges.

I understand that in the case of emergencies or special circumstances, any exception to this policy is solely at the discretion of Osteopathic Wellness, LLC management.

_____ Date: _____

Signature