FOR INTEGRATIVE MEDICINE, LLC & DE MELLO MEDICAL CORP

CONFIDENTIALITY AND PAYMENT AGREEMENT

Last Name: ______________________________ **First Name:** ______________________________

DOB: _________/_________/_________ **Today's Date:** _________/_________/_________

A: The Akasha Center follows HIPAA guidelines. If you have not received a copy of the **Notice of Privacy Practices** explaining these guidelines and how we implement them, you may request one from our office or download one from our website www.akashacenter.com

Initial here ___________ to acknowledge that you have read our HIPAA guidelines and agree with our approach.

B: In addition to the HIPAA guidelines, we are passionate about strictly protecting the confidentiality of all our patients. We also strongly emphasize an integrative team approach to wellness, prevention, diagnosis and treatment of disease. Therefore, it is of significant importance that our practitioners regularly come together, as a team, to discuss the various treatment modalities that we may be employing to treat you.

[ ] I authorize* the Akasha Center practitioners to discuss my diagnosis & treatment options with:

____ **Akasha Practitioners**
____ **External Practitioner(s)** ____
(Outside the de Mello Medical Corp and the Akasha Center for Integrative Medicine, LLC)

**This authorization does not include the release of medical records. Patients must be asked to sign a release form in order for the Center to release medical records*

C: [ ] I authorize the Akasha Center to release information to my insurance company, pertaining to my care, in order for them to process a claim which is being submitted for reimbursement.

D: Please read thoroughly and acknowledge that you will adhere to the following Akasha payment policies:

1. I am responsible for paying fees at the time of service. Accepted forms of payment are personal checks, Visa, MasterCard & American Express. I will be responsible for a $25.00 service charge for insufficient funds.

2. I have provided credit card information and understand that I will be held responsible for a ***cancellation fee for the full cost of the missed visit if I do not cancel with at least a 24-hour notice or do not arrive for my appointment.*** If I cancel within the 24-hour period and **reschedule the appointment within 1 week**, the cancellation fee will be waived for ***one time only.***

3. If I opt to submit insurance claims, I will be provided a Superbill to submit to my insurance company. When submitting my claims through Akasha's billing service, I agree to an administrative fee of $20.00. Because the Center has signed out of Medicare, I understand that I cannot bill Medicare for any services rendered at the Center

4. I understand that supplements and herbs **are not** included on Superbills and unopened supplements **are returnable** within 30 days of purchase and opened supplements **are not** returnable.

Prescription Refill Requests

There may be a charge for prescription refills authorized or written at any and all times, other than a scheduled office visit. This includes any special orders into pharmacies.

I have read and agree to the above terms and conditions

Print Name: ____

Signature: ____ **Date:** _____/_____/______