GREEN HOUSE
NATURAL MEDICINE

109 Ponemah Rd, Ste 9

Amherst, NH 03031
(603) 249-5771
www.greenhousemedicine.com

PATIENT CONSENT FORM

Thank you for allowing Greenhouse Natural Medicine to serve you. Please complete this consent form to receive services.

CONSENT FOR TREATMENT

I hereby give my consent to receive comprehensive health services at Greenhouse Natural Medicine. I further authorize any health professional working for Greenhouse Natural Medicine to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my health care. This includes examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician or Nurse Practitioner, consulting physicians and their associates and assistants, or rendered by Greenhouse Natural Medicine personnel under the instructions, orders or direction of such physician(s).

_____ (patient/guardian initials)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of all of my insurance benefits, payable directly to Greenhouse Natural Medicine. I understand that I am responsible for any charges not covered by my insurance company.

_____ (patient/guardian initials)

PROMISE TO PAY

I understand that I am obligated to pay in full for any services received in accordance with the regular rates and terms of Greenhouse Natural Medicine. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Greenhouse Natural Medicine visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

_____ (patient/guardian initials)

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CANCELATION POLICY

I understand that I am obligated to provide at least 24-hour notice if I am unable to keep a scheduled appointment or I will be charged full price for any missed appointment.

_____ (patient/guardian initials)

CONSENT FOR ELECTRONIC COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I consent to receive text and/or email messages from the practice as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

_____ (patient/guardian initials)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Greenhouse Natural Medicine's Notice of Privacy Practices that provides information about how Greenhouse Natural Medicine may use and disclose my protected health information. I have read and understand the above information and give permission for my care as described. I understand that I have the right to OPT-OUT of any medical testing or treatment. I also understand that I may obtain further information regarding the health services offered by Greenhouse Natural Medicine by contacting (603)249-5771.

Patient Name: _____ Date of Birth: _____

_____ _____

Patient/Guardian Signature Date