FAMILY RENEWED™
Dawn M. Porter, MD

Patient Last Name, First Initial

CLIENT AGREEMENT AND ACKNOWLEDGEMENT UPDATE 2018

The purpose of this document is to provide patient updates on practice changes and billing in 2018 and obtain current releases of information for patients.

NO SHOW/LATE CANCELLATION POLICY

Patient (please print):_____ Birthdate:_____

I UNDERSTAND THAT I MUST GIVE **24 HOURS** ADVANCE NOTICE DURING REGULAR BUSINESS HOURS IF I OR MY CHILD IS UNABLE TO KEEP HIS/HER SCHEDULED APPOINTMENT.

APPOINTMENT TYPE	**Follow-Up (FU)**
NO SHOW FEE (Not billed to Insurance)	**$100**
LATE CANCELLATION FEE (Not billed to Insurance)	**$50**

I understand and acknowledge the 24 hour cancellation/ No Show policy: ☐ **YES** ☐ **NO**

We appreciate your efforts in keeping your appointments or canceling them within 24 hours so that we are able to offer this time to another patient that may be waiting for an immediate appointment.

Thank you.

_____

Patient Name Date

_____

Parent/Guardian (please print): Date

_____

Parent/Guardian Signature Date

_____

Witness Date

1670 Essex Way, Suite A101, O'Fallon, IL 62269
3636 S. Geyer Road, Suite 100, St. Louis, MO 63127
Phone: (314) 238-7240·Fax: (877)300-4369·www.familyrenewed.com

CLIENT AGREEMENT AND ACKNOWLEDGEMENT UPDATE 2018

HIPPA ACKNOWLEDGMENT

Patient (please print):_____Birthdate:_____

Parent/Guardian, authorized person (or patient if minor has turned 18 during the course of service) must initial in the space provided ( ) prior to any treatment being rendered or continued.

PRIVACY POLICY: I hereby acknowledge receipt of the "Notice of Privacy Practice/Policies" of Dawn M. Porter, MD of Family Renewed, LLC. I have reviewed the documents on the date indicated below. I understand the limits of confidentiality, privacy policies, my rights and their meanings and ramifications. I further acknowledge that if I have any questions about this notice, I may contact Dawn M. Porter, MD of Family Renewed, LLC. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Dawn M. Porter, MD of Family Renewed, LLC. I further authorize Dawn M. Porter, MD of Family Renewed, LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Dawn M. Porter, MD of Family Renewed, LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____)

_____

Patient/Parent/Guardian (please print): Date

_____

Patient/Parent/Guardian Signature Date

_____

Witness Date

Parent/Guardian Signature Date

_____

Witness Date

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CLIENT AGREEMENT AND ACKNOWLEDGEMENT UPDATE 2018

Authorization for Release of Health Information between Dawn M. Porter, MD and our Primary Care Physician.

I, _____, request that health information regarding my or my child's care and treatment be released to/from Dawn M. Porter, MD of Family Renewed, LLC, of Illinois or Missouri, as set forth on this form.

I further acknowledge that I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my initials on the appropriate line in item 5.

In the event the health information described below includes any of these types of information mentioned above, I will initial the space on the appropriate line in item 5, and specifically authorize release of such information between Dawn M. Porter, MD of Family Renewed, LLC and my or my child's primary care physician listed on line 3.

1. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 3. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

2. Signing this authorization is voluntary. I understand that generally my treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

3. Name, Address and Phone of Person(s) to/from whom this information will be disclosed:

_____

_____

_____

4. Purpose for Release of Information:

_____

_____

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Authorization for Release of Health Information between Dawn M. Porter, MD and our Primary Care Physician.

5. Unless previously revoked by me, the specific information below may be disclosed for a period of one year from today's date unless specified here.

From: _____ (start date) until _____ (expiration date).

All health information (written and oral may be released between the parties specified above), except:

_____

For the following to be included in the release, indicate the specific information to be disclosed and initial in the space provided.

_____ Mental Health Clinical records/information
_____ Records from alcohol/drug treatment programs
_____ HIV/AIDS related information to be disclosed

6. All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT (If patient is 13 years or older) DATE

_____ _____
SIGNATURE OF GUARDIAN (include relationship) DATE

_____ _____
SIGNATURE OF WITNESS DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

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