# The Centre for Renewal, LLC
# Patient Agreement

**Please initial each line and sign at the end of this form:**

_____ I _____ _____ (patient name & date of birth) authorize medical and health care treatment by Dr. Traci Shahan, NP., DNP

_____ I understand that all prescriptions, refills, lab test orders, referrals and letters will be taken care of at the time of an appointment.

_____ Unless emergent, lab test results are not reviewed by phone. If, due to long distance or the inability to come to the office for an appointment, a 30 minute phone appointment may be scheduled to review results. This appointment will be conducted after you have established care and provided credit card information, which we will keep on file and charge for the appointment.

_____ I acknowledge that a copy of the Notice of Health Information Privacy Practices will be available at the office, and I will take a copy at my visit if I wish to keep a copy.

_____ Dr. Shahan respects your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operations, or as specifically authorized by you.

_____ Dr. Shahan notifies her patients about the results of all tests that are ordered, regardless of whether the findings are normal or abnormal. Occasionally, the results do not get sent to the office. If you have undergone routine medical testing and have not received the results within 14 business days, please call the office to ensure that the results of all completed tests are reported back to you.

_____ I authorize Dr. Shahan to release my medical information to any physician or health care practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. This also extends to records regarding my child, if applicable.

_____ I agree to a $20.00 fee for returned checks.

_____ I agree to a $20.00 fee for any charges that are not paid at the date of service.

_____ Cancellations or failure to show for an appointment with less than 24 hours notice will result in a $50.00 fee. Exceptions will be made for inclement weather or other situations that make it impossible to be present.

_____ I understand that payment is due at time of service. It is my responsibility to verify the hourly rate at the time I schedule my appointment. I understand that rates may change and will be posted online at thecentreforrenewal.com.

_____ I understand that Dr. Shahan does not participate in insurance plans, including Medicare. I understand and agree that the doctor does not accept assignment, which means that payment will be required at each visit. I will receive a Superbill showing the cost and nature of the services and it will be my responsibility to submit the claim to my insurer.

_____ I understand that Dr. Traci Shahan has an “opt out” agreement with Medicare such that if I have Medicare with or without a secondary, I cannot submit to Medicare for reimbursement. I understand and have signed the Medicare Patient Agreement in this regard if applicable.

_____ Payment is due at the completion of the office visit. Payment in full by cash or check on the date of service will receive a 5% discount. There is no discount for credit card payments. I understand that I am responsible for all charges incurred for treatments rendered, even if my insurance company determines that any services are non-covered or excluded.

_____ I understand that insurance reimbursement may not be available. My insurance company may not pay for office visits where the focus of the consultation is on wellness or herbal medicine, etc. Also, some of the lab tests that are ordered are kits sent to labs using innovative approaches to diagnostics and may not be reimbursed.

_____ I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

_____ I may revoke these authorizations in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

**I have read, understand, and agree to the Authorizations and Acknowledgments sheet, and I am prepared to establish care in this practice.**

_____ _____

Patient/Guardian Signature Date