CentreSpringMD
INTEGRATIVE MEDICINE BY DR. TAZ

Welcome to your medical home!

We look forward to meeting you at your upcoming new patient appointment. You have made an important decision to take a deep look at your health, and we are honored to join you in that pursuit.

We hope that your experience leads you to a better understanding of your health and how it impacts and resonates through every aspect of your life. I have worked hard to build a team that is dedicated to your health and committed to excellence. We guarantee a partnership and a source of support as you move through the many phases and faces of "healthy."

Your new patient appointment is the longest, so please plan ahead. We take a deep dive into your health history and what is going on in your body. Your comfort and experience are of the highest importance to us, so please inform our staff of any issues you may have during your appointment time.

If you have any concerns or conflicts with your appointment time, please reach out to our scheduling coordinator.

My team is committed to your health and honored to be on this journey with you. We will see you soon!

To Your Best Health,

Taz Bhatia, M.D.
Founder and Medical Director
CentreSpring MD

Patient Information

Date: _____

Name: _____
Last First MI

Email address: _____

❑•Check to receive email appointment reminders.

Mailing Address: _____

_____

Phone (H)_____ (W) _____ (Other) _____

❑•Check to receive text appointment reminders Phone Carrier: (Verizon, AT&T, etc.) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____

Phone: (H) _____ (W) _____

Primary Care Physician: Name: _____ Fax: _____

Address: _____

_____

Stay Connected

Directions: Check mark the boxes below to indicate how you would like to hear from us.

CentreSpring MD

☐ CentreSpring MD Newsletter

☐ Product Promos & Sales

☐ Upcoming Classes & Events

☐ Dr. Taz MD Newsletter

☐ I do not wish to receive any emails from CentreSpring MD or Dr. Taz.

Health History

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems		❑ Shortness of Breath
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No

If yes, explain _____

List any medications you are currently taking: _____

_____

List any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

List any allergies: _____

List any supplements you are currently taking (vitamins/herbs/minerals): _____

Previous experience with CAM (alternative medicine):

_____

Previous abnormal lab results:

_____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑Heart Disease_____ ❑Diabetes _____
❑Cancer _____ ❑Arthritis _____ ❑Other _____

Do you exercise: ❑Frequently ❑ Moderately ❑ Occasionally ❑ None
(Please list any current exercise routines or physical activity)

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Are you satisfied with your current work/career? ❑ Yes ❑ No

What is your typical work/career routine?

Do you use recreational drugs or alcohol? ❑ Yes ❑ No If yes, explain _____

Do you engage in any other high-risk behaviors? ❑ Yes ❑ No

Do you attend or practice any form of religion or spirituality? ❑ Yes ❑ No

Describe your home environment:

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach

What do you do for fun or relaxation?

What is your daily/weekly intake of the following?

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

Personal History: (Briefly describe your past health, vitality and any factors that may make you feel better or worse).

Goals/Objectives:

Main Purpose of Consultation:

Patients Concept of Condition: (Please describe your perception of your current health and how your condition affects your vitality).

GYN History: (Please list your menstrual history, pregnancies, etc.)

GYN Complications:

Previous Hormone Use:

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE _____ DATE _____

Diet History:

Please list all food, drinks, and snacks consumed in the last 24 hours:

_____

_____

_____

Sleep History:

Typical bedtimes: _____ Typical wakeup times: _____

Average number of hours of sleep per week: _____

Medications or supplements used to help sleep: _____

Thank you for providing us with this information. Please bring any pertinent medical records to your first visit. We look forward to serving you.

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information seen by Medicare will be kept confidential by Medicare.

Wait times in office. While we strive to care for patients in a timely manner, we attract complex patients which can extend visit times and impact wait time for other patients. Our average wait time can run between 30 minutes to 1 hour. If you are pressed for time at your visit, please inform our staff.

Visit Fee Charges. All office appointments scheduled and seen will incur an office visit fee at the time of visit. If you have question regarding fees, please speak with a patient care coordinator who will be happy to answer any questions regarding costs.

APPOINTMENT POLICY FORM

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here.

Missed/No Show Policy:

- With the exceptions of unexpected emergencies, we require that you notify us at least 48 business hours in advance as to any appointment changes.
- **All New Patient Appointments without a 48-business hour notification will be charged a service charge, which varies per provider.**
- There is a service charge for no-call/no-show appointments, and the service charge is the amount of the visit you were scheduled to have.

Late Policy: If you are going to be late for your appointment, please call the office. If you arrive 20 minutes or more after your appointment time, it is up to the provider's discretion and availability on whether you will be able to still be seen.

*****Please allow 4 hours for your new patient visit.*****

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

Administrative Form Fee Policy

CentreSpring MD requires an administrative form fee for each patient for completion of forms, letters and medical records (requires additional authorization). Forms include but are not limited to: medical record requests, workman's comp, handicap forms, disability, social security forms, FMLA, school physicals (brought in outside of an appointment), letter for attorneys, insurance, employers, schools, and others as per the discretion of the practice.

One-time Fee (at new patient visit) *This covers any forms for the life-time of the patient.*	$25
Fee per Form (if not paid at new patient visit)	$35 *per form*

❑ I will pay the one-time administrative form fee of $25. Initial _____

❑ I will pay for each individual form for a fee of $35 per form. Initial _____

Collection Fees and Interest Charges

All checks and credit cards returned to or declined at CentreSpring MD due to insufficient funds, closed accounts, or any other reason may be subject to the following fees and interest charges:

- Returned checks or Credit Cards in the amount of $250.00 or less will be subject to a $20.00 collection fee and a $20.00 insufficient funds fee.
- Returned checks or credit cards greater than $250.00 will be subject to an interest charge of prime + 2%, which is currently 10.25%. In addition, returned checks or credit cards greater than $250.00 will be subject to a collection fee equal to 19% of the returned check amount or amount of credit declined.
- I understand that if a balance is carried on the account, the credit card on the account will be charged the full amount, plus any interest that follows.

By signing below, you acknowledge and understand the terms and conditions of all information above regarding financial responsibility, payments and fees.

SIGNATURE (X) _____ DATE _____

PATIENT INSURANCE AND LAB SERVICES WAIVER

Our office appreciates your help in keeping your insurance information current with EACH visit. This information helps our staff to properly advise you of which lab may or may not accept your insurance. It is also vital for any outside lab we use, as we provide them with a copy of the information we have on file for their billing purposes. **All lab specimens (blood, urine, PAP smears, and fecal matter) are sent to outside laboratories. We provide only lab draws, which have a fee of $25 each to cover the sanitation and proper handling of your specimen.** Please make sure you present your lab card or make us aware if your insurance company requires that your lab tests be done by a specific lab. This helps as we do not bill or accept assignment of benefits.

You may or may not be billed by the laboratory; this is at the sole discretion of the laboratory and your insurance, NOT CentreSpring MD. We will only bill you for collecting the specimen only. The lab will file a claim or bill you separately for performing the ordering test.

LAB TESTS WILL BE BILLED SEPARATELY FROM THE LAB CHOOSING OF YOUR CHOICE.

I FULLY UNDERSTAND AND AGREE THAT I AM RESPONSBILE FOR THE FOLLOWING CHARGES:

- Any non-covered service as deemed by my insurance
- Any out-of-network charges
- Co-payment or deductibles as deemed by my insurance policy
- Payment is due in full at the time of service
- If the lab is not contracted with my insurance company, I understand that I will pay in full and file a claim myself.
- If my insurance coverage changes, it is my responsibility to contact the laboratory with the necessary information.

_____	_____	_____
Patient Name (Print)	***Patient Signature***	***Date***

Navigating Your Experience

You booked your appointment, now what? We have put together this guide to help you navigate your experience at CentreSpringMD.

(If you are an out-of-town patient, please visit our website for more information—CentreSpringMD.com/Patients.)

New Patient Visit

Average Appointment Duration: 3 hours

The typical entry into the practice, this appointment is our chance to understand the current framework of your health and begin the process of treatment planning. During this visit, we will obtain lab work, and also determine what additional services you may need to get you on the path to reclaiming your health, including an average of 30-45 minutes with your provider. *Because we do a deep dive into your healthy, please allow 3-4 hours to complete your visit (check-in to discharge).*

Your provider may recommend both conventional and integrative labs. Conventional labs can be processed through your insurance, so bring your insurance card with you.

You will leave this visit with an individualized Phase 1 treatment plan. The Phase 1 plan is based on your history and our clinical assessment of your needs. This plan will include a variety of recommendations—all tailored to you. In the case your provider feels further research is needed before formulating your plan, it will be emailed to you within 48 hours. Your plan may include vitamin and nutrient supplementation. All of our supplements are third-party tested and pharmaceutical grade.

Please let the staff know if you are bringing in outside lab work as there will be an outside lab fee. While our providers do not mind reviewing these, it does require more time and likely extend the duration of your visit.

Follow-Up Visit

Scheduled 4-6 weeks after initial visit
Average Appointment Duration: 1.5-2 hours

Your next visit is the follow up, which varies in length by complexity. The provider reviews your labs and creates your Phase 2 treatment plan based on your progress. He or she may recommend more specific lab work as your progress is charted.

Please allow 1–1.5 hours to complete your appointment (check-in to discharge). You will have an average of 30 minutes with your provider. If your visit becomes complex, and the provider spends more than 45 minutes with you, your follow up will be classified as an Extended Follow-Up, which is a different visit level/charge.

Abbreviated Follow-Up Visit

Scheduled variably

Average Appointment Duration: 1 hour

Your provider will determine the rate of your subsequent follow-ups. Shorter in length, these visits are more focused on specific issues, since the framework for your overall health should be set. You will have an average of 20-30 minutes with your provider. *Please allow 1 hour for your in-office time (check-in to discharge).*

The majority of our patients are seen every 3 months until stable, and then 1-2 times per year.

Sick Visits

We do accept patients for sick visits. Please call and book early in the day to help our schedulers fit you in! Sick visits are scheduled with first-available providers, including nurse practitioners.

Phone Consultations

We offer phone consultations for our out-of-town patients (only). Complex labs that result in a significant change in treatment are considered follow-up visit and will incur a charge, although handled by phone.

Courtesy Phone Calls
For critical lab results, care or confusion that is best served through a phone call, we will give you a courtesy call. These are usually 15 minutes in length to clarify confusion or address concerns. These are scheduled at the beginning or end of the provider workday. Please be flexible with these times.

Email Access

Patients have direct email access to their providers, which we have found improves communication and your care. Your provider can address specific questions or concerns answered in a few sentences, but will not be able to offer lengthy discussions regarding your care. We do not charge for email, but it is up to the discretion of your provider as to when these concerns should be addressed via a follow-up visit in the office. Please limit email to specific, focused questions. Emails longer than 6 sentences could incur a fee.

Lab Work and Results

Since we offer both integrative and conventional lab work, lab results return to our office at staggered times. Integrative labs take 3-4 weeks on average to return. We will call you once we have the first set of labs in our system to make sure you have an established appointment.

If you are only doing routine labs, and not labs as a part of your first visit, the providers will interpret these labs and have their comments emailed to you. Again, if complex, you may be called to set up a phone consult to redirect your care. This does not happen often, but is a possibility.

Note: When using American Clinical Laboratories (ACL), you may receive and "Explanation of Benefits" in the mail. This is NOT a bill.

Here is how we will report your results:

- A lab review following a recent appointment for an established patient will be emailed.
- Patients with critical lab results will receive a phone call.
- If labs are complex, you will receive a phone call.
- New Patient labs will be reviewed at a follow-up visit.
- A lab review for a patient who has not had a visit within six months will require a vist.

Appointments

Your care is important to us, and we have developed a team model to ensure our patients experience continuity of care with each provider. If your provider of choice is not available, please be open to seeing another provider. Our providers work together to collaborate on and work to master your care. For an appointment with a preferred provider, plan to book ahead of time to guarantee a spot. You can also ask to be placed on our master waitlist for your provider. Again, this does not guarantee that an appointment will be available in the allotted time, although as providers, we all work for that goal.

Payment*

Payment is due at time of service. We do not accept insurance, but we can provide you with a claim form for you to submit directly to your insurance company.

New Patient Visit (excludes integrative labs)	$325 – $695 (contingent on provider level)
Extended Follow Up	$190 – $275
Follow UP	$175 – $250
Abbreviated Follow Up	$95 – $150
Phone Consult- Clarification	$50 – $250
Sick Visit	$85
Outside Lab Fee	$100 – $200 (contingent on provider level)

All prices listed are subject to change without notice. Every effort is made to provide the most accurate and up-to-date information. Please call for most up-to-date pricing.

CENTRESPRING MD

CONSENT FORM

Documentation of Informed Consent and Assumption of Risk Regarding Use of Complementary and Alternative Medical Therapies; Notice Regarding Insurance Practices; Notice of Privacy Practices and Medical Records Release Authorization

By signing this form, I, _____ [**name of patient**] acknowledge that:

Primary Care. I have engaged CentreSpring MD through its physicians, nurse practitioners, nutritionists, acupuncturists, ayurvedic practitioners and specialists in other modalities ("**Treating Provider**") to provide ongoing medical care and treatment for my condition and to serve as my primary treating provider. I understand that Treating Provider's practice (the "**Center**") is located in Georgia, that the Center's practitioners are only licensed in the state of **Georgia** and that all my care will only be provided at the Center. I understand that Treating Provider will manage my care and shall be responsible for following me through routine office visits, performing history and physical examinations, prescribing medications and making clinical recommendations regarding my care and treatment. I agree that Treating Provider may withdraw as my primary treating provider upon reasonable notice, which would generally be considered 30 days' notice unless there are extenuating circumstances.

CAM Therapies. In addition to my primary care, I have engaged Treating Provider for advice that integrates his/her knowledge of complementary, alternative, holistic, integrative and functional medicine (collectively, "**CAM**") therapies. Treating Provider has described his/her education, experience, and credentials (if any) relating to these CAM or nonstandard therapies. Recommendations for pharmaceuticals may be for uses not specially approved by the United States Food and Drug Administration ("**USFDA**") (including recommendations which are known as "off-label" uses) and for dietary supplements and nutraceuticals which may not be approved for any medical indications by the USFDA. I understand that the care provided by Treating Provider is highly specialized and based upon information that may not be widely recognized within the medical profession, or in some cases about which there may be disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or may be considered by my medical insurer or government agencies as medically unnecessary, even though the recommendations may nonetheless be therapeutically appropriate and constitute good clinical care.

Referrals. I understand that Treating Provider may also refer me for additional care to one or more allied health providers, such as a licensed psychologist, or to CAM providers such as, for example, a chiropractor, an acupuncturist, or a massage therapist, either within or outside the Center. I understand that referral to a provider within the Center will have no financial impact on my care, and that I am free to see comparable providers outside of the Center. I further understand that the Center is a business practice location only, and as such practitioners within the Center may not be employees of Treating Provider, and that Treating Provider may not be responsible for their care or quality of care.

Disclosures and Discussion Required Informed Consent. Treating Provider and I will be discussing sufficient information**,** including the risks and benefits of including or forgoing the suggested diagnostic and therapeutic approaches, to enable me to decide to include or forgo these approaches in my treatment regimen. Our conversation will include:

1. the nature of my medical/psychiatric condition and any conventional care required for my treatment;

2. the nature and probability of any significant risks or contraindications or side effects involved with respect to including those CAM, nonstandard or other therapies Treating Provider recommends or delivers (to the extent known and adequately documented in the existing medical literature), including the fact that the safety, efficacy, and mechanisms for some of these CAM, nonstandard or other therapies may not be completely known even though limited information from clinical trials may exist; the fact that the treatment is experimental or nonconventional; and that some of these therapies could adversely interact with conventional medications I am currently taking or that are prescribed by Treating Provider or other health care provider, or with conventional procedures such as surgery;

3. the benefits to be reasonably expected from the CAM, nonstandard or other therapies, to the extent known as documented in the medical literature;

4. the inability of Treating Provider or current medical science to predict results with respect to inclusion of the CAM, nonstandard or other therapies; and the fact that therapies we have discussed may be emerging therapies that are not uniformly considered proven or acceptable, despite available clinical data;

5. the need to continue my primary medical care and my psychiatric care (to the extent relevant) with my primary treating psychiatrist, as appropriate, and to ensure that inclusion of CAM, nonstandard or other therapies recommended does not cause a delay in, or discourage conventional diagnosis of (or care for) any medical condition (including a psychiatric condition) I may have, or interact adversely with any conventional medication I may be taking;

6. the possibility that Treating Provider may refer me to other practitioners, including CAM providers and allied health practitioners to offer helpful therapeutic services, although Treating Provider cannot guarantee results from their care and is not responsible for the quality of care they may or may not be able to provide; and

7. other treatment options, whether conventional, nonstandard or CAM, that I might consider in choosing the best treatments for my condition.

Treating Provider will inform me that this form supplements and forms a part of my medical record by serving to document my acknowledgment that Treating Provider and I will have a sufficient conversation to enable me to make a voluntary, knowing and intelligent decision with respect to inclusion of CAM or nonstandard or other diagnostic and therapeutic approaches in my treatment. My consent to using all the above approaches, whether considered conventional, nonstandard, emerging, or CAM, is given voluntarily, without coercion, and may be withdrawn, and I am competent and able to understand the nature and consequences of my decision.

Assumption of Risk. I knowingly, voluntarily, and intelligently assume all risks involved in using CAM, nonstandard or other therapies that Treating Provider recommends. As a result of my assumption of these risks, I agree to release, indemnify, and defend Treating Provider and it's agents, representatives and affiliates, from and against any and all claims which I (or my representatives) may have for any loss, damage, or injury arising out of or in connection with use of such therapies, or arising out of or in connection with referral to other practitioners for such CAM, nonstandard or other therapies. I further acknowledge that it is my responsibility to inform my other health care providers concerning my decision to use the CAM, nonstandard or other therapies so they can determine, within their professional competence, whether any harmful or adverse effects are possible given their treatment of my medical condition.

No Guarantees. I am aware that the practice of medicine is not an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnostic approaches or treatment recommendations that I receive from Treating Provider.

Notice to Patients Regarding Insurance Participation of Treating Provider. I understand that Treating Provider does not participate in any healthcare insurance plans or state or federal health care programs, including Medicare. I understand that I will be responsible for payment in full at the time of service for all services provided by Treating Provider at the Center, that services rendered may not be covered by my insurer, HMO or other third party payor, and that charges are determined by Treating Provider and are not subject to negotiated fee amounts. I am aware that if any unpaid balance is on my account, my account will be charged the full amount and may also include interest charges at a rate of 26.99%. Further, I understand that if my plan provides reimbursement for services by out-of-plan providers, and I wish to submit a claim myself (except for Medicare claims) to request reimbursement, it is my responsibility to know my plan benefits and submit a claim. Treating Provider is not responsible for determining my eligibility for benefits or for assisting me with collecting insurance benefits, and has no responsibility to correspond with or telephone or email any insurance carrier. I agree that I will be financially responsible for any charges for services provided by Treating Provider even should my insurer, HMO or other third party payor determine that those services are non-covered or are medically unnecessary or inappropriate.

Notice of Privacy Practices and Medical Records Release Authorization. Treating Provider will inform me of the following:

As you are no doubt aware, major changes in Federal privacy requirements (the Health Insurance Portability and Accountability Act ("HIPAA")) obligate most physician practices to provide you with notice of your privacy rights with respect to your medical information. These requirements were put in place because so much patient information is now being shared in digital format over computer networks. Because Treating Provider does not participate in insurance plans or Medicare, and does not submit claims electronically to Medicare or any health insurance plan for any services provided by Treating Provider, Treating Provider is not subject to HIPAA. Nonetheless, Treating Provider remains committed to protecting the confidentiality of your personal health information. You should understand the following with regard to how Treating Provider treats your personal health information:

1. This form authorizes release of information allowing us to provide personal health information to your insurance company for the purpose of assisting you in obtaining payment and to any health care practitioner to which a Treating Provider practitioner refers you for care. The authorization also allows us to request and obtain records from practitioners that you have seen for the purpose of assisting us in your treatment.

2. We cannot release information to family members, other than parents or legal guardians, even if they are involved in your care, without your written permission. If you wish records sent to a health provider you have not yet seen, a family member, an attorney, or other party outside of the list below, you must first sign a release of information before we can forward your information.

3. In order to ensure quality of care, Treating Provider's records may occasionally be reviewed both internally and by outside consultants in legal, clinical, record keeping and other concerns that can affect the quality of the services we provide. Only necessary information is accessed, and any such review is performed by professional staff working under the condition of confidentiality.

4. If you wish to limit the nature of information that is released, or the parties noted above to whom information may be provided, please discuss these limitations with Treating Provider or the Center's office manager. In some instances, Treating Provider may not be in a legal position to honor your requested limitations, or there may be consequences that you need to be aware of, such as limitations upon receipt of insurance payment or upon the quality of care delivered. It is best to discuss any such concerns in advance. Further, we may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are court orders in connection with criminal or civil litigation, or requests/surveys by licensure agencies or

the U.S. Department of Health and Human Services.

5. You may revoke (in writing) your authorization for the future release of information. We may in that event decline to provide further treatment.

6. Although Treating Provider is not subject to HIPAA, Treating Provider will continue long established and useful business practices, such as providing you with appointment reminders, notifying you of lab results, or using sign-up sheets, but will take steps to do so in a fashion that takes your privacy expectations into account. Treating Provider reserves the right to charge for the copying and forwarding of your health record. While the records of the care we provide are Treating Provider's property, we will make them available for your inspection and provide copies at a reasonable fee. If you have any concerns about your health records, please see the Center's office manager.

Mindful of the above privacy practices, I authorize Treating Provider to release my medical information to any allied health and CAM providers within the Center, or to any physician or health practitioner to whom I am being referred for care, and to any payor of my care including my insurance company or managed care program upon their specific request. I also authorize Treating Provider to receive any medical information or records required from any of my other health care providers, and/or any allied health and CAM providers within the Center, in order to perform the services described above. This authorization may be revoked by me in writing at any time.

I HAVE CAREFULLY READ THIS FORM AND ACKNOWLEDGE THAT I UNDERSTAND IT. NO REPRESENTATIONS, STATEMENTS, OR INDUCEMENTS, ORAL OR WRITTEN, APART FROM THE FOREGOING WRITTEN STATEMENT, HAVE BEEN MADE. This form will be interpreted under Georgia law, and Georgia will be the forum for any lawsuits filed under or incident to this form. If any portion of this form is held invalid, the rest of the document will continue in full force and effect.

I HAVE HAD THE CANCELLATION POLICY EXPLAINED TO ME BY CENTRESPRING MD AND UNDERSTAND I WILL BE CHARGED THE FULL COST OF A VISIT IF I FAIL TO GIVE 48 HOURS NOTICE PRIOR TO CANCELING MY APPOINTMENT.

Name of Patient	
Signature	