Amaro Integrative Medicine

"A.I.M. for the path to a healthier you!"

Certified in Family Medicine & Osteopathic Manipulative Treatment

Conditions of Treatment Statement

I, ______________________________, allow Amaro Integrative Medicine to begin treatment and agree to follow my providers recommendations regarding treatment, therapy, medications, specialty referrals, and return visits to help promote continuity of care.

I also understand that I am ultimately financially responsible for all professional services.

I understand that the failure to follow my provider's instructions or meet financial obligations may be grounds for termination from the practice.

____ ________________

Print Name Date

____

Signature

1901 Medi Park Dr. Ste 1048
Amarillo, TX 79106
Phone: (806)576-4999
Fax: (855)259-1838

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for allowing Amaro Integrative Medicine, PLLC to assist you with your health care. In the interest of good health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect as stress-free as possible.

As a courtesy to you, we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim. **Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay.**

Co-Pays, Deductibles and Co-Insurances are due at the time of service. You will begin receiving monthly statements with any balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact Office Manager, Haley Amaro, at (806)576-4999. The balance of the account is due within thirty (30) days.*

Please contact the clinic if you are not able to keep your scheduled appointment. Appointments should be cancelled at least 24 hours in advance.

I, the undersigned:

( ) have insurance coverage, and authorize direct payment from my insurance carrier to Amaro Integrative Medicine, PLLC.

> *Note: You are responsible for knowing your coverage benefits. (i.e.: Coverage on the following: Office Visit, Osteopathic Manipulation Treatment, Injections, Lab Work, Allergy Test & Treatment, and any additional services performed by Amaro Integrative Medicine and its partners)*
>
> ******Reminder--* Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay.**

( ) do not have insurance coverage and understand that I am responsible for payment of all charges in full at the time of service.

X____

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Patient Release of Medical Records Form (Please Print or Type)

Date______________________________

To________________________________

Address ____________________________ City____________________ State__________

Phone: ____________________________ Fax: ______________________________

I hereby request that my medical records be released to:

Amaro Integrative Medicine

1901 Medi Park Dr. Suite 1048, Amarillo, TX 79106

Fax: (855)259-1838

Patient's Name (please print)____

Patient's Signature____

Address____________________________City___________________ State_____ Zip_______

Phone Number_______________________ Fax Number______________________________

Date of Birth_________________________ Social Security #__________________________

Comments____

____

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*****If Faxing or mailing the Release of Medical Records Form to the Medical Clinic, include a copy of a photo ID such as a State issued Driver's License, State Issued ID Card, or Passport.***

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Authorization for Release of Information to Family Members

Patient Name:______________________ Date of Birth:____________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Amaro Integrative Medicine to release my medical and/or billing information to the following individual(s):

1.________________________ Relation to Patient:____________________
2.________________________ Relation to Patient:____________________
3.________________________ Relation to Patient:____________________

Patient's Consent

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient. You have the right to revoke this consent in writing.

Signature:______________________________Date:________________

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Clinic Policy Regarding Controlled Substances

Amaro Integrative Medicine seeks to provide our patients with evidence based, quality care. Our approach is to use the best treatments with the least possibility of harm. Therefore, we do not prescribe narcotics, benzodiazepines, and many other chronic controlled substances.

Examples of narcotics NOT prescribed for chronic conditions:

- Hydrocodone
- Oxycontin
- Percocet
- Codeine

Examples of benzodiazepines NOT prescribed:

- Xanax (alprazolam)
- Ativan (lorazepam)
- Klonopin (clonazepam)
- Valium (diazepam)

Examples of controlled medications NOT prescribed for Adult ADD/ADHD:

- Adderall
- Ritalin
- Concerta
- Vyvanse
- Focalin
- Metadate

We will be happy to care for your comprehensive health needs, and refer you to pain management or psychiatry if you choose to continue these medications.

**These are not exhaustive lists so please ask if you are not sure if your medication falls under these categories.

I have read and reviewed the above policy regarding controlled substances.

Name________________________________ Date ____/____/____

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NOTICE OF PRIVACY PRACTICES & PATIENT ACKNOWLEDGMENT

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please call our office at the number below or mail a letter to:

Amaro Integrative Medicine

1901 Medi Park Dr. Suite 1048

Amarillo, TX 79106

Phone: (806)576-4999

Fax: (855)259-1838

By accepting this form, you are only acknowledging that you have been provided our Notice and understand the contents.

Signature:

X____

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Medication Refill Policy

1. It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to ***TWO BUSINESS DAYS*** so please be courteous and ***DO NOT*** wait until you are out of medication to call.
2. If you are ***NOT*** taking a controlled medication, please ***CONTACT YOUR PHARMACY*** and ask them to contact us. This will speed up the refill process for you as they can communicate with us by fax.
3. There will be ***NO*** early refills of any controlled medications. Please be sure to follow your prescription exactly.
4. ***Medication refills will only be addressed during regular office hours.*** The on-call provider will not return any phone calls regarding refills. Please notify your provider on the next business day if you find yourself out of medication after hours.
5. Some medications require a prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and provider. The providers and pharmacies are familiar with the process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of approval status. Please check with them for updates on your request.
6. It is ***Important*** to keep your scheduled appointments to ensure you receive timely refills. If you are unable to keep your appointment you may be required to wait until your next appointment to receive a refill. This will be determined on a case-by-case basis, ***BUT PLEASE NOTE:*** Repeated no shows or cancellations will result in a denial of refills, as well as an associated ***fee***.
7. If you would like a prescription called to a pharmacy, please be sure to leave your ***name, the name of the patient, the name of the medication and the phone number of the pharmacy***. Refill requests left without the pharmacy phone number will not be called in. This is to ensure that the correct pharmacy is notified.
8. If you have any questions regarding your medications, please discuss these during your appointment with your provider. If for any reason you feel your medication needs to be adjusted or changed please contact your provider immediately.

X____

Signature

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