Office Policy and Consent to Use Confidential Health Information

Release of Information

All information provided from page 01 to page 04 is true and accurate to the best of my knowledge. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care assignees and/or beneficiaries and other related persons. I acknowledge that my provider may also send thank-you cards for referrals. I understand that ACT does not otherwise sell or share this information without prior consent. I have read and understand this release policy.

Payment Policy

Payment of all services rendered is due at the time of service to ACT, unless other arrangements are made in advance. I have read and understand this payment policy.

Appointment Cancellation Policy

I understand that 24 hours' notice is required when canceling an appointment. I also understand that the full cost of the visit will be charged if I do not cancel 24 hours prior to the appointment. I have read and understand this cancellation policy.

My signature below indicates that I have read the above information and understand the payment and referral policies, and procedures described above.

Name of Patient (Please Print)

Signature of Patient **Date**

OSTEO
Integrative Holistic Medicine

2000 W Koenig Ln
Austin, TX 78756
www.osteo.us