

## **Consent and Authorization for Treatment**

### **Treatment Authorization**

By signing this form, I, \_\_\_\_\_ authorize medical treatment for myself by Integrative Lyme Center of Rhode Island, LLC.

### **Notice as to Nature of Services**

I understand that the care provided by Integrative Lyme Center of Rhode Island, LLC. is highly specialized and based upon evidence-based medicine, including Functional Medicine and holistic principles, and in some cases, there may be disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. Diagnosis and treatment may include some services that are considered non-traditional, non-conventional or complementary or alternative medicine (“CAM”). These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental or investigational. They are, however, recognized by the American Holistic Nursing Association.

### **Financial / Insurance Responsibility**

I understand and agree to each of the following policies regarding financial and insurance responsibilities. Payment in full is required at each visit. Donna does not accept assignment, nor does she accept any insurance.

### **Claim Management**

Integrative Lyme Center of Rhode Island, LLC. may provide claim forms for submission to insurance, but submission is the patient’s responsibility. Caseload demands do not allow time for this office to respond to insurance requests for information. *The fee for copies of your records is \$20 for handling.* Integrative Lyme Center of Rhode Island, LLC. is not obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.

**No Guarantee**

I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to outcomes of any treatment that I receive from Integrative Lyme Center of Rhode Island, LLC.

I will continue to remain under the care of my primary care provider and specialists if applicable for any ongoing allopathic care and evaluation that might be indicated. Integrative care is adjunctive to the treatments that I am receiving by my treating primary health care provider.

I have carefully read this form and acknowledge that I understand it. No representations, statements or inducements, oral or written, apart from the forgoing written statement have been made. This form shall be governed by the laws of the state of Rhode Island which shall 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 shall continue in full force and effect.

**Medical Records Release Authorization**

I authorize Integrative Lyme Center of Rhode Island, LLC. to release my medical information to any health care practitioner to whom I am being referred to for care, as well as your insurance company, or Medicare carrier, upon their specific request. I also authorize any health care practitioner I have seen to release my medical records including diagnostic test results to Integrative Lyme Center of Rhode Island, LLC. This authorization shall be effective for one year and may be revoked in writing at any time.

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***Patient Signature***

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***Date***

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***Clinician Signature***

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***Date***