Acupuncture Physicians of Colorado
Rosalie A. Bondi, D.O., M.A.O.M.
9101 Harlan Street Suite 350
Westminster, Colorado 80031
720-381-6100 Fax: 720-381-6133

Authorization to Release/Obtain Health Information

I, _____ authorize Acupuncture Physicians of Colorado, to obtain my health information containing my complete medical records to include psychological or psychiatric conditions for the purpose of medical evaluation and treatment. This information should be disclosed to and use by Acupuncture Physicians of Colorado.

_____ _____ _____
Print Name Signature Date

Notice of Privacy Practices

Before completing this section, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your Protected Health Information (PHI). You may request a copy of the Notice of Privacy Policies at any time.

I have read and understand the Notice of Privacy Practices for Acupuncture Physicians of Colorado and consent to the use of my PHI for the purposes stated.

_____ _____ _____
Print Name Signature Date

Workers' Compensation Information/Missed Appointments (if applicable)

I understand that the Workers' Compensation Law authorizes the physician to provide information about my medical care for on-the-job injuries or illnesses to my employer.

I understand that it is my responsibility to attend all scheduled appointments with medical providers including primary workers' compensation physicians, specialists and all therapies, including acupuncture. My insurance adjuster and the referring physician/workers' compensation physician(s) will be notified of missed appointments. Missed appointments include no shows, repeated cancellations and reschedules which will affect the maximum medical benefit of acupuncture therapy.

_____ _____ _____
Print Name Signature Date

Consent/Permission to Treatment

I hereby consent to diagnostic and/or medical treatment and/or examination by any of the physicians of Acupuncture Physicians of Colorado and/or by their technical/clinical assistants.

_____ _____ _____
Print Name Signature Date

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Financial Responsibility

I hereby accept responsibility for all charges incurred for treatment and that is not covered by my insurance. I authorize Acupuncture Physicians of Colorado and its medical providers to apply for benefits on my behalf for services rendered by their order. I authorized the release of any medical or other information necessary to process my insurance claims. I request that payments from my insurance company be made directly to Acupuncture Physicians of Colorado. I agree to pay reasonable attorney and/or collection agency fees if my account is turned over to an attorney and/or collection agency. I permit a copy of this authorization to have the full authority of the original signed copy.

Workers' compensation patients have no financial responsibility. Although, I understand any treatment obtained after Maximum Medical Improvement (MMI) and/or when the claim settles on a full and final basis will be the responsibility of the patient. I will notify Acupuncture Physicians of Colorado when the claim reaches MMI and/or settlement to avoid financial responsibility.

_____ _____ _____
Print Name Signature Date

Cancellation/No-Show/Reschedule Policy

The physicians of Acupuncture Physicians of Colorado are committed to providing quality care. If you do not present for your appointment, or cancel/reschedule with little notice, we are unable to fill that time slot and cannot run our office efficiently. Therefore, our policy requires that you give us at least 24 hours notice (not including weekends and holidays) if you need to cancel or reschedule your appointment. Failure to show up for your appointment or a cancellation/reschedule less than 24 hours before the appointment will result in the patient being billed $50.00. Appointments will not be rescheduled until all fees have been paid. Thank you in advance for your cooperation.

_____ _____ _____
Print Name Signature Date

Late Arrival Policy

Due to the complex nature of your treatment and in consideration of other patients, you may be asked to reschedule if you are late. You are asked to arrive **10 minutes prior** to your *follow-up appointment* time so that you will be ready **in the room** for your treatment at the appointment time.

_____ _____ _____
Print Name Signature Date