

Consent Form C&S Holistic Family Health & Wellness

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C&S Holistic Family Health is a Functional Medicine practice that services families of all ages.

Functional Medicine is a collaboration between the patient and the provider. I meet you and your family where you are, listening to your story and striving to help you maintain health and wellness beyond just the absence of disease.

C&S Holistic Family Health & Wellness does not bill insurance. Payment for services is due at the time of your appointment. Payment can be made as either cash, check, credit or debit card. C&S Holistic Family Health & Wellness will provide a coded receipt to you for services rendered. Since C&S Holistic Family Health & Wellness is out of network it is the patient/client responsibility to work with their insurance to seek any reimbursement with out of network benefits. C&S Holistic Family Health & Wellness does not assist with reimbursement of any kind with insurance companies. If you are either Medicaid or Medicare, you will not be able to apply my services to these insurances.

C&S Holistic Family Health & Wellness requires that all intake and consent forms be returned 24 hours prior to scheduled appointment so they can be reviewed. This allows C&S Holistic Family Health & Wellness to obtain an understanding of your history along with having respect for your time. C&S Holistic Family Health & Wellness has a cancellation policy. **It is required that** **you give 48 hour’s notice for cancellation of an appointment or you will be billed for that appointment.**

I agree to reimburse Practice its out-of-pocket costs, plus fifty dollars ($50.00) for any chargebacks I request.

Appointments at C&S Holistic Family Health &Wellness may be done either in the office setting, by telephone or through zoom video platform.

C&S Holistic Family Health & Wellness offers patients the opportunity to communicate by email. Transmitting patient information by email, however, has several risks that patients should consider before giving consent. These risks, include, but are not limited to:

1. Email can be circulated, forwarded, and stored in numerous paper and electronic files.
2. Email can immediately broadcast worldwide and received by both intended and unintended recipients.
3. Email senders can misaddress senders.
4. Email can be more easily falsified than handwritten or signed documents.
5. Backup copies of email may exist even after the sender of the recipient has deleted his or her copy.
6. Employers and online services have a right to archive and inspect emails transmitted through their systems.
7. Email can be intercepted, altered, forwarded, or used without authorization or detection.
8. Email can be used to introduce viruses into computer systems.

Cherri Schleicher FNPc APNP FMCHC will use reasonable means of the most up to date software for security protection to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above and factors beyond her control, Cherri Schleicher FNPc APNP FMCHC cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information that is not caused by the Providers intentional misconduct. Thus, patients must consent to the use of email for patient information with the following conditions:

1. All emails to or from a patient concerning diagnosis or treatment will be made part of the patient’s medical record. Because they are a part of the medical record, other individuals authorized to access the medical records, such as staff and insurance companies will have access to those emails.
2. Cherri Schleicher FNPc APNP FMCHC will not forward emails to independent third parties without the patient’s prior written consent, except as authorized or required by law.
3. Although Cherri Schleicher FNPc APNP FMCHC will endeavor to read and respond promptly to email from the patient, Cherri Schleicher FNPc APNP FMCHC cannot guarantee that any email will be read and responded to within any period. Thus, the patient shall not use email for medical emergencies or other time sensitive matters.
4. If the patients email requires or invites a response from Cherri Schleicher FNPc APNP FMCHC and the patient has not received a response within a reasonable time period, it is the patient’s responsibility to follow-up to determine whether the intended recipient received the email.
5. The patient is responsible for informing Cherri Schleicher FNPC APNP FMCHC of any types of information the patient does not want to be sent by email regarding sensitive medical or personal information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, issues of abuse, developmental disability or substance abuse.
6. The patient is responsible for protecting his/her password or other means of access to email. Cherri Schleicher FNPc APNP FMCHC is not liable for breaches of confidentiality caused by the patient or any third party.
7. Cherri Schleicher FNPc APNP FMCHC shall not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines without established patient physician relationship.

**Instructions to communicate by email, the patient shall:**

1. Inform Cherri Schleicher FNPc APNP FMCHC of any changes to his/her email address.
2. Put his/her name in the body of the email.
3. Include the category of communication in the emails subject line (i.e. billing question).
4. Review the email to make sure that all relevant information is provided before sending to our office.

Signature for Consent for Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_

Signature to Financial Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_

Signature to consent for

Email communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_