Denise Bahadar MSN, FNP
LiveWell Natural Health
Boise, ID 83713
(208) 392-8383

RELEASE AND WAIVER OF LIABILITY AGREEMENT

I, _____ (client), acknowledge that I have read and understood the contents of this agreement.

1. Live Well Health and Nutrition, PLLC ("LiveWell Natural Health") makes no representations, claims, or guarantees regarding the efficacy of their natural health recommendations. The recommendations are based upon a combination of clinical experience, education, and knowledge of natural health literature.

2. Individualized recommendations are offered and applied as an educational and informative consultation. Any action taken as a result of the consultation is done at the sole discretion of the client. Therefore, it is strongly recommend that in addition to any health consultation that you maintain a relationship with one or more physicians qualified to care for your health condition(s).

3. By signing this informed consent you agree to forever release LiveWell Natural Health from any and all actions, claims or demands that you, your heirs, next of kin, spouse and legal representatives now have, or may have in the future related to your participation in a natural health consultation. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against LiveWell Natural Health. If a legal case is brought against LiveWell Natural Health, you agree that LiveWell Natural Health shall be judged by the standards and principles of complementary, alternative, and holistic medicine and not the standards and principles of consensus conventional medicine.

4. Your signature verifies that you have not been told to discontinue treatments with any medical specialists or other health care providers. Your signature is being given prior to rendering any service, advice, and/or recommendations whatsoever.

5. LiveWell Natural Health makes available nutritional supplements and other health products. You are in no way obligated to purchase these products from LiveWell Natural Health or any other specific vendor. You may freely choose to purchase such products from any source.

6. Natural health consultations provided by LiveWell Natural Health may not be covered by your insurance plans. By signing this form you accept full financial responsibility for all costs associated with the consultation including laboratory tests and treatment procedures provided by others. A charge of $30 will be added for all bounced checks. LiveWell Natural Health holds the right to refuse to accept personal checks.

7. It is the responsibility of the client to set up follow up appointments for results of all testing and laboratory procedures. It should not be assumed on the part of the client that if they are not contacted by LiveWell Natural Health, or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

8. **Cancellations must be made at least 48 hours prior to the scheduled appointment. Due to the limited time slots available, if you fail to show up to your scheduled appointment you will be charged a full office visit fee. If you fail to cancel your appointment within 48 hours of said appointment, there will be a full office visit charge. _____Initials

By entering your signature below you are acknowledging that you understand all terms, language, and concepts herein.

I fully understand this consent agreement, and I have executed it freely and willingly.

_____	_____	_____
Printed Name	Signature	Date

Consent For Care And Treatment

I, the undersigned, do hereby agree and give my consent for Denise Bahadar MSN, FNP to furnish medical care and treatment to _____as considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian_____Date_____

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you or services billed by us, you recognize an obligation to promptly remit that payment to LiveWell Natural Health.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Note: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.
The above information has been read and I fully understand it.
I understand my full responsibility for the payment of my account.

Patient/Guarding/Responsible Party_____Date_____

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NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____ understand that as part of my health care, LiveWell Natural Health originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, &
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that LIveWell Natural Health is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that LIveWell Natural Health reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should LiveWell Natural Health change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email). I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

_____ _____ _____

Name Signature Date