



CONSENT TO CARE, TERMS AND CONDITIONS

**CONSENT TO CARE:** I hereby consent to allow Dr. Elina Chernyak, D.O. (DBA Wholistic IntegraCare) to provide medical and other care, including but not limited to examination, diagnostic procedures, and treatments. I acknowledge that I may rescind this consent at any time. Signatures of all legal guardians are required for a minor to be treated.

**FINANCIAL RESPONSIBILITIES:** I agree to pay for all services and products provided by Dr. Elina Chernyak, D.O. (DBA Wholistic IntegraCare). I acknowledge that this medical practice operates on a "fee-for-service" basis and does not contract with any medical insurance company\*.

All services/products must be paid for at time the service or product is provided. I agree to pay the appropriate fees for any type of consultation or treatment, whether provided in person or by telephone or email. Dr. Elina does not routinely charge for brief telephone or email conversations of 5 minutes or less to discuss particular urgent or acute care, or after hours problems.

If for any reason I have an outstanding balance on my account, I permit Dr. Elina Chernyak, D.O. (DBA Wholistic IntegraCare) to charge my credit card to clear any outstanding balance.

I have been given an opportunity to view a copy of the HIPAA privacy laws under which Dr. Elina Chernyak, D.O. (DBA Wholistic IntegraCare) practices.

**APPOINTMENTS:** Please honor the 24-hour cancellation policy for all appointments. Please call or email to reschedule. A fee of \$25 will be charged for no-shows or cancellations within 24 hours of your appointment.

**DISCLOSURE OF HEALTH INFORMATION:** I consent to the use or disclosure of any protected health information by Wholistic Integracare LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wholistic Integracare LLC.

I understand that diagnosis or treatment of me by Dr. Elina Chernyak may be conditioned upon my consent, as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice.

I have the right to revoke this consent in writing, at any time, except to the extent that Wholistic Integracare LLC has taken action in reliance on this consent. My protected "Health Information" includes demographic information collected from me, and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical and/or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

I understand I have a right to review HIPAA Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills and in the performance of health care operations of Wholistic Integracare LLC. The Notice of Privacy Practices also describes my rights and the Doctor's duties with respect to my protected health care information. HIPAA reserves the right to change the privacy of practices that are described in the Notice of Privacy Practices. A revised copy will be provided upon request via US Mail, email or at the time of my next appointment.

**PRESCRIPTIONS:** Please allow **72 hours** for prescriptions (either new or refills) to be called into the pharmacy. Please be observant if your medicine is running low or if you know you will be traveling, and call ahead of time. Please note that the compounding pharmacies will contact you directly for billing and shipping information, and notify you of their own policies for when prescriptions will be shipped.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Name of Minor (if applicable):** \_\_\_\_\_

**Signature** of Patient/Parent/Guardian (circle one) \_\_\_\_\_

\*Wholistic IntegraCare is a Fee for Service Practice. Insurance is not accepted due to the policies of medical insurance companies dictating to doctors which patients receive which treatments and medications, how they are treated, and which doctor they can see. Dr. Chernyak categorically rejects this model of healthcare as it does not revolve around your best interests. Our treatment model puts the patient first, and allows us to provide top quality personal care without insurance company restraints.