Terms of Service / Client Provider Agreement

- **I understand that Lynn A. Chadd, ARNP does not accept insurance as payment and that I am responsible for payment in full at the time of service.**
- **I have read and agree with the cancellation policy.**
- I understand that if Medicare is my insurance, I cannot self bill Medicare for reimbursement as per Medicare's billing policy. I am agreeing to pay "out of pocket" for all services, at the time of service.
- I understand that the main focus of Lynn Chadd's practice is preventive healthcare, integrative care of chronic disorders, and treating hormone imbalance in men and women. **I understand that Lynn Chadd does not provide after-hour, urgent, emergency or on-call care.**
- I have been advised to have a Primary Care Provider for my general health care needs.
- I have been advised that in the event of an emergency I should dial 911 or go to my local emergency room.
- I have provided accurate medical history information on the Medical History Intake Form.
- I understand that all of my records and information will be confidential according to "The Healthcare Privacy Act".

Legal Name _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Preferred Phone for Msgs** _____

Email _____

We will use email to deliver our newsletter, messages, and general correspondence. Please opt in or out of email communication by circling your preference below.

Newsletter? Yes No Messages, reminders and general correspondence? Yes No

Signature _____ **Date** _____