General Office Policies

Please review each paragraph and sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies.

RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA): I have been given the opportunity to read a copy of the Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records.

CONTACT PERMISSION: In the event that Glow Health Medical Clinic needs to contact me (patient) regarding an appointment, test result, medication, medical instructions, or any other reason, it is permissible to (check all that apply):

- ○ OK to leave detailed message on voicemail.
- ○ OK to send detailed message via text.
- ○ OK to send detailed message via email.
- ○ OK to speak with spouse/significant other.
- ○ OK to speak with other family member.

CONSENT TO TELEPHONE/EMAIL COMMUNICATION: I understand that any phone or email communication will be part of my medical record. I also understand that email is not to be used for any emergent matters, and response will be given back generally within three business days.

CONSENT TO TREATMENT: I consent to the performance of examinations, diagnostic procedures, and treatment by Glow Health Medical Clinic. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

CONSENT TO REFER: I authorize the staff to release pertinent records to any physician they refer me to for further care. I understand that this office will not use or disclose my medical information without my written authorization.

CONSENT TO PHOTOGRAPH: I authorize Glow Health Medical Clinic to take photographs/videos of me to be used in my medical record, not to be released without my prior authorization.

APPOINTMENT CANCELLATION/RESCHEDULE POLICY: Please call or text the office at 415-287-2920 as soon as you realize you need to reschedule/cancel your appointment. Please keep in mind that we have reserved this time just for you.

If ***CANCELING a visit less than 48 business*** hours in advance, cancellation/no show fee of **$150** will be applied. If an appointment is ***RESCHEDULED within 24 hours*** of original appointment time, a late change fee of **$75 may/will be charged.**
Thank you for your understanding.

Print Patient Name: _____ Date: _____

Signature: _____