Oasis HEALTH SPA
Spa Policy

720 North 30th Street ~ Billings, MT 59101 ~ Phone (406) 294-7778 ~ Fax (406) 545-0044

Appointments and Reminders:
Please arrive 5-10 minutes before your appointment to fill out paperwork and to get settled into the spa. Your appointment time has been specifically reserved for you. Please arrive promptly in order to receive your full treatment time. *If you are unable to make your appointment, please inform us at least 24 hours prior to your scheduled time*. **Failure to provide us with 24 hours notice of appointment cancellation will result in a charge to your account for the full amount of the service.**

Optional email and/or text reminders are a courtesy service we offer our spa patients. Please note that you are responsible for your appointment time ***regardless of whether or not you receive a reminder***.

Email: _____ **(Please Circle One)** Opt **IN** or **OUT**
→*for appointment reminders and continuing care*

Cell Phone: _____ ____ **(Please Circle One)** Opt **IN** or **OUT**
→*for customer promotions, appointment reminders, continuing care, birthday messages, thank you messages*

Fees, Insurance and Accounts Receivable:
Fees are dependent on the service provided, please see our price list. **We expect payment at the time of service.** Note that Yellowstone Naturopathic Clinic/Oasis Health Spa accepts VISA, Discover, MasterCard and American Express. If you have insurance coverage along with a doctor referral including diagnosis codes we can provide you with an insurance form that includes all the appropriate procedural and diagnostic codes your insurance company will need to process your claim.

Phone Consultations and Questions:
Please feel free to discuss with us any questions you may have in person or via phone (406) 294-7778 our staff will get back to you as soon as possible. Should you have several questions regarding your treatment or progress, we suggest that you make a consultation appointment so that we may properly meet your needs.

Emergencies:
One of our doctors is on-call 24 hours a day. Calls to the Clinic at (406) 259-5096, outside regular business hours, are automatically transferred to our answering service, who will then contact the doctor and your call will be returned. For medical emergencies, please call 911.

Acknowledgements:
We hope that you will find your visit with us pleasant as well as beneficial. Our goal is to help you in building better health.

Signing this form acknowledges that **you understand and accept the policies** of the Yellowstone Naturopathic Clinic/Oasis Health Spa.

Print Name: _____DOB:_____

Failure to provide us with 24 hours notice of appointment cancellation will result in a charge to your account for the full amount of the service. _____ (Please Initial)

Signature: _____Date:_____

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliant Officer. You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Patient's Representative(s): (the following must be filled out, even if the answer is none)
This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.

***I hereby authorize the following individuals to have access to my healthcare information:**

_____,Relationship to Patient _____
_____,Relationship to Patient_____
_____,Relationship to Patient_____

TERM

This consent will be in effect for one year from the date signed.

Printed Name of Patient _____ Date_____

Patient or Responsible Party Signature _____

Responsible Party's Relationship to Patient _____

Witness _____ Date_____

*** If you would like a copy of this form, once signed, please ask the receptionist ***

Patient Compliance Assurance Notification

To our valued families and patients:
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!

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