info@completeimage.org
(440) 461-4247
6555 Wilson Mills Rd, Ste. 105
Mayfield Village, OH 44143

# Complete Image

## Notice of Cancellation Policy

Complete Image requires a 24-hour notice of appointment cancellation to avoid penalty.

Complete Image reserves the right of refusal after multiple appointment cancellations or “no call, no shows.”

If you arrive more than 10-15 minutes late to your scheduled appointment, the provider may not be able to perform a service that day.

If you fail to arrive for your scheduled appointment without a 24-hour notice, a percentage of the missed service will be due upon your next appointment.

Of course, we understand when emergencies arise but please be mindful of your providers’ and fellow clients’ time.

We also ask that in the case that if you fall ill on the date of your appointment, that you reschedule your appointment for at least 48 hours after you starting exhibiting symptoms. This would not be cause for any penalty.

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## Return Policy

At Complete Image, we strive to provide products and services that best met the client’s standards.

If you feel that we are not meeting these standards, please let us know within **one week** of the purchase.

Beyond that point, we are not able to provide a replacement of these services or products

**With these forms please include:**

A prescription from your doctor

The medical reference number from your insurance company.

A copy, front and back, of your insurance card and State ID/driver's license

# Complete Image
## Acknowledgements

**Patient Name**: ________________________________________

I hereby acknowledge that I have received a copy of the Complete Image Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

I hereby acknowledge that I have received a copy of the Complete Image Cancellation Policy.

I hereby acknowledge that I have received a copy of the Complete Image Return Policy.

_______________________________________________
**Signature of Patient or Legal Representative**

_______________________________
**Date**

_______________________________________________
**Printed Name of Patient's Representative (*if applicable*)**

**Relationship to Patient (*if applicable*)**
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

# Patient Intake Form

## Basic Information

**Full Name:** ______________________________________________________________________
First Middle Last Suffix

**Sex:** ◯ Male ◯ Female ◯ Unknown

**Date of Birth:** ________/________/_________

**Primary Phone:** ◯ Home ◯ Mobile ◯ Work

**Phone Number:** ________________________________

**Email:** ___________________________________________

**Address Line 1:** ___________________________________

**Address Line 2:** ________________________________________

**City:** _____________________________________________

**State:** ______________

**Zip Code:** _______________

## Emergency Contact

**Full Name:** ______________________________________________________________________
First Middle Last Suffix

**Primary Phone:** ◯ Home ◯ Mobile ◯ Work

**Phone Number:** _______________________________________

# Complete Image
## Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Complete Image to use and/or disclose my protected health information as described below to

**(Name and address of recipient):** ______________________________________________________________________________

______________________________________________________________________________

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

______________________________________________________________________________

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I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Complete Image in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Complete Image agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

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I authorize payment of medical benefits directly to the physician for services rendered.

I understand that I am responsible for all co-payments, coinsurance and services deemed “non-covered” by my insurance.

I authorize my physician to act as my agent in assisting me to obtain payment from my insurance companies.

**Expiration:**
This authorization will expire 180 days from the date of signing or **(insert date)** ____________________________.

**Patient Name:** ______________________________________

**Patient ID #:** _______________________

_______________________________________________
**Signature of Patient or Legal Representative**

___________________________________
**Date**

_______________________________________________
**Printed Name of Patient’s Representative (*if applicable*)**

**Relationship to Patient (*if applicable*)**
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

_______________________________________________
**Signature of Witness**

___________________________________
**Date**

## Complete Image
## Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize Complete Image to release my records and any protected health information requested to the following individuals.**

1. ______________________________________________ Relation to Patient: ___________________

2. ______________________________________________ Relation to Patient: __________________

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

☐ at request of individual

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**Expiration:**
This authorization will expire 180 days from the date of signing or ____________________________.

**Patient Name:** ___________________________________

**Patient ID #:** ______________________

_______________________________________________
**Signature of Patient or Legal Representative**

__________________________________
**Date**

_______________________________________________
**Printed Name of Patient's Representative (*if applicable*)**

**Relationship to Patient (*if applicable*)**
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_______________________________________________
**Signature of Witness**

__________________________________
**Date**