Functional Integrative Practice of Dr. Nadia Ali
Functional Holistic Healing
995 Old Eagle School Road, Suite 311
Wayne, PA, 19087
Ph: 610-363-3973
Fax: 484-631-1327
website: www.theholistichealing.org

Functional Holistic Healing LLC Financial Responsibility Policy.

It is the Client's esponsibility to pay for all services rendered at the time of the service. The payment can be in the form of Cash or Check. We charge a 4% fee for using credit cards.

I have read the financial responsibility policy of Functional Holistic Healing LLC. I understand the policy and I agree to the terms of the policy.

Client Signature	Date:
Client Printed Name:	

I have received a copy of the Notice of Privacy Practices and I have reviewed it carefully.

Client Signature	Date:
Client Printed Name:	

By signing this form you take full responsibility for paying for these services.

Client Signature	Date:
Client Printed Name:	

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Email Consent

- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

⬜ I authorize Functional Holistic Healing to notify me of appointments by email appointment reminders.

⬜ I authorize Functional Holistic Healing to share information about its programs, health blogs and services offered in the community, including programs or services specific to me, using email communications.

⬜ I have read and understand the potential risks of using unsecured email to communicate my protected health information.

⬜ I consent to the release of my protected healthcare information via unsecured email.

Name: _____Date of birth: _____

Signature: _____ Date: _____

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Credit Card Preauthorization

Dear Client

We prefer check or cash.

For your convenience, you may pay your account balance with your credit card. There is a 4% charge for using the credit card. Please complete the information below:

Client Name: _____ Date: _____

I authorize the health care provider shown above to charge my credit card account for my balance due for:

⬜ Past Services
⬜ This visit only
⬜ All visits

⬜ Mastercard ⬜ Visa ⬜ American Express ⬜ Other

_____

Cardholder Name _____

Charge Account Number _____ Exp date: _____

CVC # _____ Zip Code:_____

I understand that this form is valid till I cancel the authorization with written notice to the health care provider.

Cardholder Signature _____