TRI-HEALTH
Family wellness center
2253 Green Hedges Way Suite 101 Wesley Chapel,FL 33544
813-771-6851 813-771-6875
info@trihealthfamily.com

Policy and Procedures

Cancellation/ No show Policy: We understand that you may sometimes need to reschedule appointments. When we make your appointment, please understand we are reserving time for you to see our provider. This courtesy makes it possible to give the best service here at Tri Health Family Wellness Center. If you need to reschedule an appointment, please call the clinic as soon as possible or call at least 24 hours in advance.
If you have not shown up for your appointment more than one time you will be charged **$50 no-show fee.**

Payment Plans/ Financial Hardship:
Should you have extraordinary financial pressures, ask about our payment plan options. We will assist you with a payment plan, agreed to it in writing with our billing department, prior to services being rendered.

Authorization to communicate protected health information (PHI) via electronic means:
I authorize, Tri Health Family Wellness Center, LLC to communicate with me via the following electronic means: method contact information can be **text, email, video conference.**

This Authorization to Communicate PHI via electronic means expires upon written revocation I understand by selecting the method of communication above and signing below, I authorize Tri Health Family Wellness LLC, to share/communicate PHI information via electronic means to myself or my designated representative described above. I understand Tri Health Family Wellness LLC may communicate to me information such as , Telehealth visits, upcoming appointment, services recommended by my doctor, medication refills, new services offered, financial information or statements and new locations/providers at Tri Health Family Wellness LLC.

I hereby release Tri Health Family Wellness LLC and its employees from any and all liability that may arise from the release of information as I have directed. I understand emailing and texting are not secure forms of communication and I release Tri Health Family Wellness LLC from any liability. I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address it to the person or institution named above.

I understand that I may refuse to sign this Authorization to communicate PHI via electronic means and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

(continued)

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Signature _____Date _____
Print Name: _____
Signature by: ☐Patient ☐Legal Guardian ☐Proxy ☐Legal Representative