Dr. Peter Knight
Your Naturopathic Health Partner

975 Broadway, Floor 1 South Portland ME 04106
(207) 805-1129 * www.drpeterknight.com

Patient Name: ______________________________ Date of Birth: ______________

Legal Representative: ___________________________ Relationship: ______________
(if applicable)

CONSENT TO TREAT

I authorize Dr. Peter Knight to examine me and perform any tests and/or treatments that may be helpful to care for my injury, illness, or to support me with health maintenance. I understand that Dr. Knight will explain the reasons for any tests and treatments, as well as the benefits, the most common risks, and alternative courses of treatment. I also understand that I have the right to refuse any suggested examinations, tests or treatment.

I understand that urgent/emergency medical problems should be addressed to my primary care provider or by calling 911 if appropriate. I understand that I can reach Dr. Knight's answering service by calling the office main number after hours.

I understand and agree that my medical records may be released to other providers and organizations for the purpose of continuing care, obtaining payment for services, or other health center operations. I understand that this information will be treated with the same level of privacy protection I am entitled to expect from Dr. Knight.

__________________________________ ________________
Signature of Patient or Legal Representative **Date**

PAYMENT/ INSURANCE

Dr. Knight is currently in network as a specialist with the following insurance companies:

- Harvard Pilgrim
- Anthem Blue Cross and Blue Shield of Maine
- Aetna

All insurance plans are different so please contact your insurance company to determine if Naturopathic services are covered and if you need a referral from your primary care doctor. Naturopathic Doctors are considered specialists by insurance companies in Maine and therefore may require a referral from your PCP. Deductibles must be met before any visits are covered, including Naturopathic visits. **Patients will be responsible for any amount of the bill not paid for by the insurance company**. Patients are responsible to know their specialist copayment and to pay that at the time of the visit. Insurance billing is not available for phone or virtual visits. **At this time Naturopathic Doctors cannot bill Medicare, Medicaid or Maine Care in the state of Maine.**

For patients with no insurance or insurance for which Dr. Knight is not in network, you are responsible to pay for the total cost of the visit when seen. We are happy to provide you with a super bill that you can submit to your insurance provider for their consideration of reimbursement.
I take financial responsibility for the services I receive from Dr. Peter Knight. I understand that payment is expected at time of service unless other arrangements have been made in advance. Dr. Knight can accept cash, checks, money orders, Visa, MasterCard, Discover, and American Express

I understand that if I do not come for my scheduled appointment, or if I cancel or reschedule my appointment giving less than 24 hours' notice, I will be held responsible for the fee for the missed appointment. I further agree and understand that this office can only code my visit with a diagnosis that was encountered and documented in my medical record.

Signature of Patient or Legal Representative **Date**

EMAIL COMMUNICATIONS

Dr. Peter Knight is happy to use email communication as a way to support your ongoing care. Please keep in mind the following in regards to email communication:

- Email is not appropriate for urgent, time-sensitive, or emergency situations. Dr. Knight cannot guarantee that any particular email will be read and responded to within any particular period of time.
- Email messages should be something Dr. Knight can respond to quickly. He will ask you to schedule an appointment if the issue is complex or too sensitive to discuss via email. It is your responsibility to follow up and/or schedule an appointment if that is recommended to you.
- Dr. Knight commits to the use of the best available means to maintain security and confidentiality of email information sent and received, but is not liable for improper disclosure of confidential information that is not caused by our intentional misconduct.

☐ I am comfortable using email communication with Dr. Knight The email address that I would like you use for communication

is:____

☐ I would not like to use email to communicate with Dr. Knight

Signature of Patient or Legal Representative **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed Dr. Peter Knight's Notice of Privacy Practices. This document can be viewed at www.drpeterknight.com. If requested a printed copy will be provided to me.

I understand that this Notice is required by law and outlines what may be done with my Protected Health Information (PHI) both with and without my written consent/authorization. I have been given the opportunity to ask any questions I may have.

I understand that a copy of the current Notice will always be available the practice's website at www.drpeterknight.com.

Signature of Patient or Legal Representative **Date**