



## BreatheWorks Authorization Form

*(Applies to Pediatric and Adult Patients – all information provided will be kept confidential)*

### Patient Information

Patient Name / Pronouns:

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DOB:

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Responsible Party (if different):

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Best Email:

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Best Phone:

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SSN of Responsible Party:

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Primary Insurance / Insurance ID / Group #:

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Primary Insured (name, date of birth, address (if different)):

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Secondary Insurance (if applicable) / Insurance ID / Group #:

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Primary Insured (name, date of birth, address (if different)):

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## Payment Policy

- BreatheWorks will file insurance claims on behalf of patients.
- A valid credit/debit/HSA/FSA card must be kept on file.
- Co-pays are charged on the day of service.
- After insurance claims are processed, invoices will be sent; cards will be charged 2 days later.
- Treatment may be suspended if no payment is received within 30 days.
- No-show / Late Cancellation:
  - \$100 fee for missed appointments.
  - \$50 fee for cancellations within 48 hours.
  - After 3 consecutive no-shows, scheduling may be suspended.

*Acknowledgement: I have read and understand the Payment Policy.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Communication Consent

I consent to receive communication from BreatheWorks (email, text, phone) for appointment reminders, health information, and relevant updates. Standard message/data rates may apply. I understand I may opt out at any time by notifying the office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Communication & Provider Coordination

I authorize BreatheWorks to:

- Submit insurance claims on my behalf.
- Charge the credit card on file for any patient financial responsibility.
- Communicate with my referring provider, primary care provider, and any additional providers listed below:

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Photo & Video Authorization

I grant permission to BreatheWorks to use photographs/videos as checked below:

- ☐ Clinical Photographs Only (for reports and baseline documentation)
- ☐ Clinical + Educational Purposes (for internal training)
- ☐ All Uses (includes research/educational/public presentations)
- ☐ Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appointment Policy

- Appointments must be confirmed 48 hours in advance (via text/email/phone). Unconfirmed appointments may be cancelled.
- Please arrive 10 minutes early for in-person sessions, or log in 5 minutes early for telehealth with a working camera/microphone.
- Cancellations require 48 hours' notice. Late cancellations may result in a fee.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA Privacy Practices Acknowledgement

- I authorize the use/disclosure of my Protected Health Information (PHI) for treatment, payment, and healthcare operations.
- I authorize photographs/videos for clinical documentation purposes.
- I understand my rights under HIPAA, including requesting restrictions, accessing records, and revoking this authorization at any time (except where action has already been taken).
- I have received and reviewed the BreatheWorks Notice of Privacy Practices.

Patient/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To complete your patient chart and ensure accurate insurance billing, please **provide copies** of the following:

- The **front and back of your medical insurance card(s)**
- Your **driver's license or government-issued photo ID**

You may securely email these documents to: **info@breatheworks.com**.

If you prefer, you may also bring these items with you to your first appointment so we can scan them at check-in.

Thank you for helping us keep your records up to date and ensuring smooth coordination with your insurance.