

Please review and initial each section below, and sign at the end document that you have read, understand, and agree to the Financial Policy, Patient Contract and Treatment Consent of Fresno Holistic Medicine.

Payment:

- We require payment at the time of service. For payment we accept cash, health savings cards (HSA), debit cards, and credit cards.
- You remain responsible for all costs of your care, regardless of insurance coverage. I understand that I can request a superbill that may be submitted to my insurance company for possible reimbursement.

Patient / Guardian Initials: _____

Late Cancellations/Late Reschedules/No Shows:

- Due to the high demand for appointments, and because we reserve your appointment time especially for you, a minimum 24-hour cancellation notice is required. A fee of \$100 applies to all non-emergency late cancellations/ late reschedules with less than 24-hours notice. You will be charged the entire cost of a vitamin injection, if you no-show on your appointment.

Patient / Guardian Initials: _____

Fees:

- Fees for Office Visits/Procedures: These are based on the complexity of your visit and/or time we spend with you. We are always happy to explain the fees for office visits, phone consult/telemedicines and vitamin injections. The initial office visit is \$300, and subsequent office visits are \$150 for up to 30 minutes; and this is subject to change. All updated fees are posted on our website.
- Lab fees: Payment for lab tests is due at the time of service. If you are getting drawn at a Quest laboratory, you will provide payment or insurance information directly to Quest labs. **If you have Medicare or Medicaid, Quest will not bill for any of your labs even if you have secondary insurance. You will be responsible for payment of all laboratory tests.**
- Telephone Calls: All telephone contacts, which require doctor time are payable at rates of \$150 for each 30 minute increment, for established patients. No fees apply to telephone calls which can be handled by office staff. No charges apply if your doctor asked you to call.
- Returned Checks: a \$35.00 fee is assessed for all returned checks.
- Non-covered services: Natural Medicines, telephone calls, telemedicine appointments, vitamin injections, wellness care, and weight management services are common examples of services not covered or reimbursed for by insurance. All sales from our dispensary are final, and products cannot be returned. By purchasing non-covered services or products, you do so with the understanding and agreement that your insurer will not reimburse you for any such services.
- Unpaid Accounts: Accounts unpaid after 90 days are assigned to collections. Accounts assigned for collection are assessed the balance, plus collection and/or attorney fees.

Patient / Guardian Initials: _____

Consent for care: To address my health condition(s), care at Fresno Holistic Medicine may include as examples, any of the following general procedures, tests, or treatments: General Diagnostic Procedures, Counseling / Lifestyle Counseling / Exercise Prescriptions, Herbal / Natural Medicine, Homeopathy, Therapeutic Nutrition, Physical Medicine, Cranial Sacral Therapy, Minor Office Procedures, and/or Drug Therapy.

- **General Diagnostic Procedures:** including (but not limited to) lab tests, pap tests, radiology, physical examination, and other medical tests to properly diagnose my condition.
- **Counseling & Exercise Prescriptions:** For the purposes of stress management, relaxation, or treatment of psychological disorders; for improving health, prevention & treatment of disease.
- **Herbal & Natural Medicine:** Use of plants and animal materials given in the form of teas, pills, powders, liquid extracts, creams, pastes, washes, suppositories, etc, to restore normal function. These may contain alcohol.
- **Homeopathy:** Using remedies made from diluted naturally occurring substances, mixed in an alcohol or water base.
- **Therapeutic Nutrition:** Use of foods, diet plans or nutritional supplements for treatment—may include vitamin injections.
- **Physical Medicine:** Use of massage, muscle stretching, and exercise therapy to relieve pain and improve function. Physical Medicine might also include the use of heating pads, ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent and stimulation.
- **Minor Office Procedures:** Examples include the use of venipuncture to draw blood or vitamin injections.
- **Drug Therapy:** Use of prescription or over-the counter drugs to treat/control symptoms of disease.
- All all other treatments discussed and recommended by Dr. Tais and ND Associates of Fresno Holistic Medicine.

I consent to treatment. Patient / Guardian Initials: _____

Electronic prescribing. Electronic prescribing is defined as a doctor’s ability to electronically send a prescription to your pharmacy to prevent the errors that occur with hand written prescriptions. Electronic prescriptions can also allow providers to see if a medication is in your drug formulary, help you find coupons to bring the medication cost down, and also look up your medication history. By initialing you are agreeing to allow Dr. Tais and ND Associates to send prescriptions electronically on your behalf to your pharmacy and also use your prescription medication history from other providers for treatment purposes.

Patient / Guardian Initials: _____

Accessing blood work from Quest, UltraLabs and Lab Corp. Our electronic medical records (Elation Passport) is able to sync to various laboratories. We are able to sync these and upload them into our EMR so that we can better understand your medical history.

Patient / Guardian Initials: _____

Personal representative: a personal representative is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as any family member, friend or individual designated by the patient to whom the patient’s health information may be disclosed. In the space below, **if so desired**, please indicate any personal representative who are permitted to receive or know information concerning your health care. If your designated personal representatives change after this form in in effect, please contact the office in writing and request the change. You may also write in “none”.

Name(s): _____

Patient/ Guardian Initials: _____

Phone consults and telemedicine which is defined as the use of electronic information and communication technologies (such as Zoom) by a health care provider to deliver services to an individual; and hereby consent to Fresno Holistic Medicine providing health care services to me via telemedicine upon choosing to schedule a phone or telehealth visit.

- I authorize Dr. Setareh Tais, ND and ND Associates to perform diagnosis, consultation, treatment, education, care management, self-management via information and communication technologies otherwise known as **Telehealth**. I understand that I must be present in the state of California when communicating with the doctor.
- I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Tais and ND Associates.
 - 1) my suspected diagnosis or condition
 - 2) the nature, purpose and potential benefit of the proposed care
 - 3) the inherent risks, complications, potential hazards, or side effects of the treatment or procedure
 - 4) reasonable available alternatives to the proposed treatment / procedure
 - 5) the possible consequences if treatment or advice is not followed and/or nothing done.
- With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by Dr. Tais and ND Associates regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time. We do not refund office fees if you decide we are not a good fit.

I consent to care via phone and telehealth. Patient / Guardian Initials: _____

Patient’s Responsibility:

- Keep your provider fully informed of health concerns or history. Keep your provider informed about prescription, herbal, or over-the-counter medications, vitamins or other things you are taking or using.
- All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies/procedures used could present a risk to the pregnancy.
- Notify your provider of any questions, problems, or concerns regarding treatment.
- Work with your provider and/or office staff to resolve any concerns.
- Keep your provider informed of all treatment recommendations from other practitioners, as well as keep other providers informed of treatment recommendations from your provider.
- Be familiar with and agree to abide by the most current Financial Policy, fee schedule, policy regarding cancellations and telephone contacts; keep account up-to-date and paid in full.
- Agree to allow the clinic to share information as needed for purposes of treatment or billing.
- Understand, review, and accept, the clinic’s HIPAA Privacy Policy, and consent to treatment.

Patient/ Guardian Initials: _____

Established medical relationship: It is important to your health that you visit your doctor once every 12 months. If you have not been seen in 12 month, we cannot renew medications or order new lab work. Some health conditions and prescriptions warrant more frequent visits, which your doctor will explain to you. If you do not have a a visit with your doctor for more than three years, you will be considered inactive. It will be at the discretion of your doctor if he/she will re-establish care and you will then have to re-establish care as a new patient.

Patient/ Guardian Initials: _____

Privacy Practices: We (Fresno Holistic Medicine) keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so, or as needed for the purposes of treatment or billing, or unless the law compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used

and disclosed, and how you can access your information. You can request a copy of the Privacy Practices at any time. I acknowledge receipt of and/or viewing of the Notice of Privacy Practices.

Patient / Guardian Initials: _____

Communication: I agree to periodic electronic mailings from Fresno Holistic Medicine regarding news, events and natural medicine educational material. I can remove myself from these mailings at any time.

My email address: _____

Patient / Guardian Initials: _____

I have read, and understand this document. I understand that I may ask questions regarding my care before signing this form and that I am free to withdraw my consent and to discontinue care (including any procedure, test, or treatment) at any time. I agree to use arbitration (an independent third party) as the exclusive method to resolve any concerns or disputes, of any nature, not handled through direct communication. With this knowledge, I voluntarily consent to care, realizing that no guarantees have been made regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Patient's Name Signature

Guardian/Personal Representative's Signature

Patient's Name (Printed)

Guardian/Personal Representative's Name (Print)

Date

Relationship/Representative's Authority