AMBERWOOD TERRACE
INTEGRATED HEALTH

_____
Patient Name

Office Policies

Booking an Initial Appointment

A non-refundable $50 appointment deposit is due at the time of scheduling. This credit will be applied to the visit total on the date of service or used as a Missed Appointment/Late Cancel Fee. See Missed Appointment Policy below.

Upon Arrival

We want all of our patients to experience a relaxed and calming atmosphere when receiving care. For this reason, we ask you to **turn your cell phone off**, or to silent mode upon entering the office.

Many of our patients and staff are highly sensitive or allergic to some fragrances and colognes; these strong smells can be overwhelming or cause discomfort. Please keep this in mind on your appointment day.

Make yourself comfortable in our reception area and one of our staff members, determined by the type of care you receive, will escort you to that specific area or room.

Missed Appointment Policy

With the exception of an unexpected emergency, we require that you notify us at least 24 hours in advance as to any appointment changes. Please call the office and leave a message if necessary.

If you are running late (traffic, flat tire, etc.) please call to see if the schedule permits for you to still see your provider. If necessary, you will be rescheduled. If you are unable to make an appointment due to an emergency, please contact us by phone so we can reschedule your appointment.

If you are 15 minutes late for an appointment and have not contacted the office prior to the scheduled appointment time to make other arrangements, the appointment is considered a MISSED appointment. Each patient will be allowed one missed appointment with no penalty, however after the first missed appointment, **the second missed appointment will be billed at $50.00, and the third missed appointment at the full visit amount (up to $150).**

Financial Policy

This office operates as a CASH practice. We accept Cash, Check, and Debit/Credit Cards. There is a service charge of $35 for any returned checks. The entire payment is expected at the time of service.

Amberwood Terrace Integrated Health (ATIH) is not in network with any insurance companies; therefore, ATIH does not accept insurance. **Patients with insurance benefits will be responsible for filing all claims on their own. ATIH will not file any insurance claims.**

If an account is not paid within 120 days of the statement date, a $50 collection processing fee will be added to the outstanding balance and will be turned over to a collection agency for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

We expect you to honor the Appointment & Financial Policy agreement you make with our office. If you find that you cannot fulfill the agreement you make with us, please inform our staff immediately so new arrangements can be made.

Patient (or guardian) Signature: _____ Date: _____

ATIH Staff: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

Initials_____ I understand that Sylvia Zakusilov, RN MSN FNP-C nor Kerrie Davis Suits, FNP-BC, MSN, RN, CFMP, ND ("The Practitioner(s)") are Medical Doctors. The Medical Director for ATIH is Wilbert Cal Streeter, DO.

Initials_____ Based on my current complaints and the history I have provided, I hereby authorize ATIH ("The Practice") and its licensed providers and assistants to undertake an examination and provide an evaluation and treatment plan that may include tests and procedures considered medically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the ATIH providers to make those decisions about my care, based on the facts that they believe are in my best interest.

Initials_____ I understand that ATIH is a Functional Integrative Medicine Practice, focusing on primarily whole-body health and wellness through the use of naturally occurring compounds as much as possible, while using pharmacologic interventions when necessary and in the best interest of the client. Integrative Medicine is personalized care that blends the best of conventional medicine with evidence-based complementary/integrative therapies. Therapies that are recommended in an integrative medicine consultation are individualized to the patient. Recommended therapies may include traditional prescription medication, mind-body modalities, biologically based therapies such as vitamins, herbs and other supplements in oral, injectable and intravenous forms, injections of various prescriptive compounds for therapeutic purposes, nutritional recommendations, exercise recommendations, other systems of medicine-based therapies such as homeopathy, and oxygen therapies.

Initials_____ Taking time for an individualized approach ensures that treatment plans are evidence-based, safe and custom-designed to meet the patient's needs and goals. It is important for you to know that the evidence base changes frequently for Integrative Medicine and that recommendations given to you are done with the evidence base available at that time for your particular condition, and that evidence and recommendations can change over time. ATIH never recommends stopping conventional Western Medical Care or treatment.

Initials_____ A Functional Integrative Medicine Practice office visit may include, but is not limited to, the following: individualized consultation with lifestyle and nutrition recommendations, individualized recommendations for supplements/vitamins/herbs including checking for drug/supplement/herb interactions, bio-identical hormone evaluations, individualized treatment protocols for your specific concerns, lab testing of blood, sputum, stool or urine, a physical examination and referral to other therapeutic providers for care not provided by ATIH.

Initials_____ I understand an office visit with The Practitioner(s) may include recommendations for various treatments as above, that evidence and recommendations may change over time, and that recommendations may also change as my individual medical condition and/or treatments change. That neither the practice of medicine, nor holistic, functional or traditional is an exact science and that my care may involve making judgments based upon the facts known to the doctor during my care. I understand that it is not reasonable to expect The Practitioner(s) to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.

Initials_____ I understand that I have the right to choose which recommendations to incorporate into my treatment plan and that I should always communicate any new treatments, including vitamins/herbs/supplements to my entire healthcare team at ATIH.

Initials_____ I understand that ATIH implies no guarantee of services concerning the results intended from any treatment and/or recommendations provided to me, that I have the right to choose my treatment plan and that I may refuse any or all treatment suggestions at any time. ATIH does not guarantee results with respect to any course of care or treatment.

CONTINUED ON NEXT PAGE.

INFORMED CONSENT FOR TREATMENT continued…

Initials_____ I understand that not following the entire protocol recommended to me may affect the results of my treatment plan and that I may not achieve the stated goals if the protocol is not followed.

Initials_____ I acknowledge that I have not been asked, without consultation, to stop/discontinue care provided by my specialty or primary care medical teams.

Initials_____ I understand that ATIH is a cash-practice and initial visits may be up to $325.00, follow-up visits up to $210; payment is expected at the time of service. A Menu of Services may be provided upon request.

Initials_____ I understand that a $50.00 appointment deposit is required upon scheduling my initial visit and will be applied toward that initial visit at ATIH. I understand that if I miss my appointment or cancel same-day of the visit, another deposit will be required to reschedule.

Initials_____ I understand that Functional Integrative Medicine information, data and drug/herb/supplement interactions databases are constantly updated as new information becomes available and that The Practitioner(s) may not be able to anticipate and explain all potential risks and complications due to the ever-changing nature of the field. I agree to allow The Practitioner(s) to exercise their best clinical judgment in my case based on the information available at my time of visit.

Initials_____ I understand all the facts given to me in this form. I give my consent to The Practitioner(s) and ATIH staff to provide initial visit and follow up services for me. I acknowledge that no guarantee of services has been made to me concerning the results intended from any treatment and/or recommendations provided to me. I attest with my signature below that The Practitioner(s) and/or ATIH staff has discussed all the information on this form, and that I have had the chance to ask questions and that all of my questions have been answered.

Initials_____ I acknowledge that ATIH has a 24-hour cancellation policy. If it is necessary to cancel my appointment, I will do so with more than 24 hours' notice. I acknowledge and give my permission that on the second time I cancel within 24 hours, or do not show up for my appointment, ATIH will charge a $50 fee. I acknowledge and give my permission that on the third time I cancel within 24 hours, or do not show up for my appointment, ATIH will charge the full amount of the scheduled visit (up to $250).

Initials_____ I understand that this document is intended as a general, broad-based consent that applies to any and all contemplated procedures. I have discussed all of the risks and benefits with my provider, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to The Practice's examination, evaluation, proposed course of care/treatments, and agree to the policies listed within this document.

_____ _____

Name of Individual (Printed) **Signature of Individual**

_____ _____

Signature of Parent/Guardian **Date Signed**

_____

ATIH Staff

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICIES

For use and/or disclosure of Protected Health Information (PHI) & to carry out Treatment, Payment, and Healthcare Operations

_____ hereby states that by signing this Consent, I acknowledge and agree as follows:

Patient Name

1. Amberwood Terrace Integrated Health's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for ATIH to provide treatment to me, and it is also required for ATIH to obtain payment for that treatment and to carry out its health care operations. ATIH explained to me that the Privacy Notice would be available to me in the future at my request. ATIH has further described my right to obtain a copy of the Privacy Notice before signing this Consent and has encouraged me to read the Privacy Notice carefully before my signing this Consent.
2. ATIH reserves the right to change its privacy practices described in its Privacy Notice in accordance with applicable law.
3. ATIH's "Notice of Privacy Practices" is also provided in the front lobby. I may also request a copy from this office at any time via US Mail or email.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my Protected Health Information.

I have read and understood the preceding Notice of Privacy Practices, and all of my questions have been answered to my complete satisfaction in a way that I can understand.

No Surprises Act

You have the right to receive a "Good Faith Estimate" explaining the cost of your medical care. Under the law, health care providers are to give patients without insurance or who are not using their insurance benefits an estimate of the bill for medical items/services. (A.) You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items/services. This includes, but is not limited to, medical tests, equipment, supplements, and services; (B.) You should receive a Good Faith Estimate in writing at least 1 business day before services/items. You can also ask your healthcare provider for a Good Faith Estimate before you schedule an item/service; (C.) If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill; (D.) Be sure to save a copy of your Good Faith Estimate. For questions or more information, visit www.cms.gov/nosurprises

I acknowledge and understand ATIH's No Surprises Act. I also understand that I am financially responsible for the cost of my visit and it is my responsibility to file any insurance claims for reimbursement.

_____ _____

Name of Individual (Printed) **Signature of Individual**

_____ _____

Signature of Parent/Guardian **Date Signed**

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ATIH Staff