Dubovoy Integrative Health, PLLC
New Patient Consent Policy
DATE:

CONTACT INFORMATION:
Name: ____
Address: ____
____
____
Age: ________________ Date of Birth:_________________________________
Phone: Cell: ________________Home: _________________Work: ______________
Pharmacy Name and Number:
____
Email Address:
____

EMERGENCY CONTACT(s):
Name: ____
Relationship: ___________________ Phone: Cell: ________________Home:
_________________Work: _________________________
Name: ____
Relationship: ___________________ Phone: Cell: ________________Home:
_________________Work: _________________________

CONSENT FOR MEDICAL TREATMENT and POLICIES

I voluntarily consent to medical treatment and diagnostic procedures provided by Dubovoy Integrative Health, PLLC and associated physicians, clinicians and all other personnel. I consent to the testing for infectious and other diseases as deemed advisable by my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments, testing or examinations. I agree that all information I convey is accurate.

CANCELLATIONS
Late cancellations (< 24 hours) and missed appointments, including scheduled phone appointments, will result in a $75.00 charge.

PAYMENT

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE by cash, check, credit, debit or HSA card. Checks returned for non-payment will be charged $75.00 plus any bank charges incurred.
WE DO NOT CONTRACT WITH INSURANCE COMPANIES, INCLUDING MEDICARE PLANS. WE DO NOT BILL INSURANCE OR COORDINATE YOUR REIMBURSEMENT.
Please contact your insurance company prior to your visit for questions regarding your out of network benefits.

FEES per encounter *
• Less than 30 minute visit = $100
• 30 minute visit = $150
• 45 minute visit = $250
• 60 minute initial visit = $400
• Well women annual visit = $300
• Prior authorizations = $50 minimum
• House calls are billed at the above rates plus $75 (within range).
• Care coordination, home health care/hospice management/faxed orders/faxed prescription refills will be billed at above rates.
• Phone calls requiring medical decision making, advice, orders or prescriptions are billed at above rates.
• Record copying/forwarding: $25 plus $0.25/page over 25 pages and postage.
• Medical care is not provided by phone, email or text.
• WE DO NOT REFILL PRESCRIPTIONS BETWEEN APPOINTMENTS. Medication refills are done at the time of appointment only. This includes pharmacy refill requests. Please plan accordingly.
• Completion of forms will be done at the above rates.
• We do not write letters to insurance companies.

*An encounter = office visit, home visit, phone visit, any issue requiring medical decision making or physician signature.

LABS
We offer laboratory testing at competitive rates. If you choose to use this service, payment for laboratory testing is due at the time the labs are ordered. I understand that should I have lab tests drawn by a different lab, I will be responsible for making sure the lab results are received by Dr. Dubovoy.

EMAIL AND TEXTING I understand my protected health information (PHI) may be transmitted via email, fax, cell phone, cell phone/computer application and/or other

electronic means of communication. I understand that once my PHI leaves the offices of Dubovoy Integrative Health, PLLC, the privacy of my PHI is not guaranteed. I understand and assume the above risk. Dr. Dubovoy is available on the office number only, not via text or email.

PAYMENT AGREEMENT I guarantee payment of all charges. I understand that I am responsible for any and all charges. I assign my rights to any insurance benefits or other funding to Dubovoy Integrative Health, PLLC. In the event that this account is placed with a collection agency or attorney for collection, I shall pay all collections fees and costs, including attorney's fees.

HOSPITALIZATION We do not provide inpatient care. Should the need for hospitalization arise, the hospital will assign a physician to care for you during your hospitalization. We will assist with coordinating care with hospital physicians.

EMERGENCY CARE This facility is not designed to respond to emergency situations. If you have an emergency, please call 911 or go to your nearest emergency room.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and AGREEMENT TO COMPLY WITH ABOVE POLICIES I have reviewed the Notice of Privacy Practices and Disclosures. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. A current copy of the Notice is posted in a visible location in the office and on the practice website (www.VAintegrativehealth.com).
I understand that I can request a copy of the Notice.
Name: ____
Date: ____________
Signature: ____

Please keep a copy of this document for your records as it explains our policies.