Dear New Patient,

We are excited to welcome you to Spencer Wellness Centre!

As a new patient to our practice, we would like to provide you with important information. Please read all forms to ensure your experience is efficient and satisfactory.

Before Your First Visit:

1. Please arrive 15 minutes in advance to your new patient appointment to complete any additional paperwork and allow time for us to complete your initial intake.
2. You will receive an invitation to our online patient portal. Here, you will be able to complete some of your new patient forms and medical history information.
3. Please be sure to bring your Driver's License, or an alternative government issued ID, and your insurance card to this appointment and all future visits.
4. YOU ARE RESPONSIBLE FOR BRINGING ALL MEDICAL/LAB RESULTS FROM PREVIOUS PROVIDERS THAT ARE PERTAINENT TO YOUR APPOINTMENT. You can request your doctor to send records to us via fax: (317) 588-3003. Please verify with their office the day before your appointment to confirm that any necessary documents have been faxed.

Appointments:
We understand that everyone's time is valuable and strive to offer convenient appointment times to all our patients. We request that you please notify us 24 hours in advance if you cannot keep your scheduled appointment; this allows us the opportunity to offer this time to another patient in need.

5. If you are going to be late, please contact our office to notify us as soon as possible: (317)588-1000 We will do our best to accommodate you!
6. If you are more than 15 minutes late, you may be asked to reschedule your appointment.
7. Please be aware that less than 24-hour notice or no-show will result in a $100 no-show fee.
8. Multiple no-shows or late cancelled appointments may result in being discharged from our practice.

Insurance:

We do NOT participate with or file claims for Medicare, Medicaid, or any HMO plans. You may elect to submit Medicare claims to your insurance provider. All labs will be filed with your insurance, regardless of insurance, plan by the testing facility. All insurance questions regarding in-network providers should be addressed directly with your insurance carrier. Our Medical Director is Marwan Mustaklem, M.D. Your insurance carrier may need this information if Nurse Practitioners are not listed.

We look forward to meeting you, assisting you with aging healthier, and living happier!

Respectfully,

Linda Spencer, FNP-C
Tierney Lara, FNP-C
Kelly Owens, FNP-C
Shelby Lane, PA-C

PATIENT REGISTRATION INFORMATION

Name: ______________________ Date of Birth: ____________ Soc Sec #: ____________

Primary Phone: ______________________ Home/Work/Cell Alternate Phone: ______________________ Home/Work/Cell

Email: ______________________ Preferred contact method: ____________

Address: ______________________ City/ST: ____________ ZIP: ____________

Marital Status: ____________ Sex: M / F Occupation: ____________

Who should we thank for referring you? ______________________

Emergency Contact Name: ______________________ Phone: ____________

Parent/Guardian Responsible for account (minors): ______________________

PRIMARY INSURANCE INFORMATION

Subscriber Name: ______________________ Date of Birth: ____________

Relationship to Pateint: ______________________ Employer: ____________

Subscriber ID #: ______________________ Soc Sec #: ____________

Insurance Company Name: ______________________ Group #: ____________

Claims Mailing Address: ______________________ Phone: ____________

ADDITIONAL INSURANCE INFORMATION (if applicaple)

Subscriber Name: ______________________ Date of Birth: ____________

Relationship to Pateint: ______________________ Employer: ____________

Subscriber ID #: ______________________ Soc Sec #: ____________

Insurance Company Name: ______________________ Group #: ____________

Claims Mailing Address: ______________________ Phone: ____________

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Spencer Wellness Centre for all insruance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I understand that failure to remit payment will result in my account being submitted to collections, at which time I will be responsible for any applicable collection fees.

I authorize Spencer Wellness Centre and/or any provider of services with Spencer Wellness Centre to release any infromation required to secure the payment of benefits. I authorize the use of this signature on all insurance submssions.

Name of Responsible Party: ______________________

Signature: ______________________ Date: ____________

Patient Consent Form

(Patient Consent for Use and Disclosure of Protected Health Information)

I hereby give my consent to **Spencer Wellness Centre** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by **Spencer Wellness Centre** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Spencer Wellness Centre** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Spencer Wellness Centre.**

With this consent, **Spencer Wellness Centre** may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Spencer Wellness Centre** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Spencer Wellness Centre** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Spencer Wellness Centre** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Spencer Wellness Centre** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing expect to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this, or later revoke it, **Spencer Wellness Centre** may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

____ _________________

Print Patient's Name **Date**

____

Print Name of Patient of Legal Guardian, if applicable

I hereby authorize payment directly to Spencer Wellness Centre for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or any dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party____Date_______________

Practice Policies and Information

Please Initial Each Section

_____ Policies

PATIENTS RIGHTS
-To be treated with respect and recognition of dignity and right to privacy. -To receive care that is considerate and respects personal values and belief system. -Personal privacy and confidentiality of information. -Reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability. -Participate in an informed way in the decision-making process regarding treatment planning. -Discuss with practitioner appropriate/medically necessary treatment options for conditions regardless of cost/benefit coverage. -Adequate and humane services regardless of the source(s) of financial support. -Voice complaints or appeals about managed care company, provider of care of privacy practices. -Be informed of rules and regulations concerning own conduct. -Request access to Protected Health Information (PHI). -Request to inspect and obtain a copy of PHI, to amend PHI or to restrict the use of PHI, and to receive an accounting of disclosures of PHI.

PATIENT RESPONSIBILITIES
I agree to provide (to the extent possible) my treating practitioner information needed in order to receive appropriate care, I understand that it is my responsibility to understand my health problems and to participate, to the degree possible, in developing with my treating practitioner agreed upon treatment goals. I agree to treat the staff of SWC in a professional and courteous manner. I understand that is my responsibility to follow plans and instructions for care that I have agreed upon with my treating practitioner.

CHECK IN PROCEDURE
Please check in with our receptionist when you arrive for your appointment. Please be sure to update any information that may have changed since your last visit (insurance, address, phone number, name, etc.) Please be prepared to pay any past balances on your account, co-pays, deductibles, and/or any non-covered services at check in. **IF YOU ARRIVE MORE THAN 15 MINUTES LATE FOR YOUR SCHEDULED TIME, YOU MAY BE REQUIRED TO RESCHEDULE SO THAT OTHER PATIENTS ARE NOT INCONVENIENCED**

MEDICAL REFILLS/QUESTIONS/CONCERNS
These topics should be addressed at the time of your appointment. **If you will run out of medications, please call the pharmacy and request that they fax our office a refill request**. If questions should arise between appointments, you may call the office and leave a message on the nurse's voicemail. The nurse will discuss the matter with the provider and return your call. The provider will not personally return your call. For extensive questions, medical decisions or new prescriptions request you will be required to schedule an appointment or phone consultation with the provider.
PLEASE NOTE: REFILL REQUESTS FOR CONTROLLED SUBSTANCES WILL ONLY BE ACCEPTED 8am-4pm, MONDAY THRU THURSDAY.

EMERGENCIES
Spencer Wellness Centre (SWC) is a private practice and is not designed as a crisis unit or primary care. In the event that you ever feel you are in a crisis DIAL 911 or go directly to the emergency room. Our after-hours emergency line is for non-life-threatening emergencies only. This line is not for prescriptions refill requests or questions that can be addressed on the next business day.

SCHEDULING & CANCELLATIONS
You can schedule or cancel your appointment by calling the office at (317) 588-1000. PLEASE NOTE: A 24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. THERE WILL BE A $100 CHARGE FOR APPOINTMENTS CANCELLED WITHOUT A 24 HOUR NOTICE

NO SHOW/LATE CANCELLED APPOINTMENTS
It is our office policy to charge $100 for EACH appointment missed or not cancelled with at least 24 hours advance notice. Payment will be due within 10 days of the missed/late cancelled appointment or at your next visit whichever occurs first. Multiple missed or late cancelled appointments may result in a discharge from our practice.

CERTAIN MEDICAL SERVICES
Some insurance companies deem certain procedures non-covered. If we feel that a service may not be covered by your insurance carrier, you will be required to sign an Advanced Beneficiary Notice acknowledging that services may not be covered and that you will be financially responsible for any bill for service.

LABS
You must have an order for lab testing in your chart or in hand for walk in services. Otherwise, you will need to schedule an appointment to obtain an order. All patients are required to schedule a follow up appointment to receive lab or other specialty testing results.
*Please refer to Notification of Lab Services for detailed policy

_____ Payment and Insurance

PAYMENTS
Acceptable methods of payment are cash, check, money order, and credit/debit cards including Visa, Mastercard, and Discover. All checks returned for non-sufficient funds will result in a $30 processing fee. The original check amount plus the processing fee must be paid prior to your next appointment or with 10 business days, whichever occurs first. SWC reserves the right of check refusal.

BILLING AND INSURANCE
SWC will file claims with your primary insurance company (other than Medicare, Medicaid, or any HMO's) upon submission of proof of insurance; however, the patient is ultimately responsible for all charges incurred. We participate with many different insurance plans. We cannot guarantee that our provider is active in your network. It is the patient's responsibility to confirm that the provider is in their network. Patients will be responsible for charges incurred because of services rendered with an out-of-network provider. It is the patient's responsibility to obtain an initial authorization for services if required by their insurance. SWC will file secondary insurance claims for contracted insurance carriers one time as a courtesy to the patient. Co-payments, deductible, and any other patient due amounts are expected at the time of service. Patients will be unable to schedule an appointment if your account is greater than 90 days past due. Accounts with a balance that is 60 days past due must pay 50% of balance due at the time of their appointment, with the remaining balance due within 30 days of said appointment. Accounts in violation of our financial policy are subject to placement with a third-party collections agency. The patient will be responsible for attorney and collection fees. For non-covered services, these charges are deemed non-covered by insurance companies and are the sole financial responsibility of the patient.

FOR QUESTIONS REGARDING ACCOUNT
Please call your insurance company directly if you have questions in regard to the way your claim was processed.

CLAIM/CHARGE DISPUTE
Front office staff, medical assistants, and/or billing office personnel are unable to waive or modify fees. The decision rests with the administration of SWC. The patient must submit a written account dispute to address any specific concerns.

DOCUMENT PREPARATION
A fee of $30.00 is required for SWC to complete paperwork (including but not limited to: work, disability, life insurance, letters, FMLA forms, etc.) Payment in full is required prior to the completion and release of said paperwork.

_____ Records and Releasing Them

MEDICAL RECORDS
A current release of information is required for all requests. All requests for medical records will be charged according to Indiana State Law. Payment is due prior to the processing of your request. There is no charge for records released directly to another healthcare professional SWC has referred to for treatment purposes.

RELEASE OF INFORMATION
A Release of Information must be completed to allow SWC to discuss appointment scheduling, billing, insurance, treatment plants etc. with designated family members, parents, guardians, other personal parties, etc. A release is not required for parents/guardians of children under the age of 18. A release must also be completed to allow SWC to send records, obtain records, or share information with other professional individuals, etc. A separate release is required for each individual and/or organization.

NOTICE OF PRIVACY PRACTICES
Our Privacy Practices are posted in our office. A copy can be provided upon your request.

Patient Name____

Signature____ **Date**_____________

NOTICE OF PATIENT'S FINANCIAL RESPONSIBILITY FOR ALTERNATIVE THERAPY

The treatments listed below are considered alternative therapy. Although SWC may be in network with your insurance provider, alternative or investigational therapies are not covered. SWC will not file a claim with your insurance provider for such therapies. The patient will be responsible for payment for the following:

Service	Patient Cost
Chelation CAD IV	$175
Chelation Metals IV Detox	$175
Vitamin B12 injections	$20
Filling out special forms/letters	$30
Spectracell Micro-Nutrients testing	$420
Vitamin C for Infusion	**$75/ 25,000mg** (dosage depends on type of IV)

The following IV therapies will be billed to your insurance provider based on the time duration of infusion, **not the product being administered**. Your benefits may or may not allow payment. You will be responsible to pay in full up to the maximum self-pay amount listed for any services not covered by your insurance.

Service	Self-Pay Cost
Glutathione IV	$75
Myers Cocktail IV	$75
Peroxide IV	$75
Immune/Vitamin IV	$150
High Dose Vit C IV	$75 - $150

Beneficiary Agreement:

I have been notified by Spencer Wellness Centre that the above listed services are considered alternative therapy and will not be submitted for Insurance reimbursement by SWC, nor can I file a claim with my insurance provider for such therapies. I agree to be personally and fully responsible for payment of the above indicated service at the time service is rendered.

____ ________________

Signature **Date**

*This agreement shall remain in effect from this date forward until rescinded in writing by the patient

Notification of Lab Services

This notification of lab services is to provide clarification regarding lab policies and patient responsibility.

Spencer Wellness Centre (SWC) offers in-office lab services as a convenience to our patients. We are not affiliated or contracted with the individual labs performing the testing. SWC does not bill for the services provided by the labs.

You are NOT required to have labs drawn in our office. You may at any time request a lab order and have labs performed at the facility of your choosing. If you have labs performed elsewhere it is your responsibility to ensure the results are sent to your provider at SWC.

If you have labs drawn in our office, the testing will be sent to Pathology Laboratories.

Pathology Laboratories is a traditional lab and in-network with most insurance carriers. Pathology Laboratories will bill your insurance and bill the patient according to insurance benefits. You will be responsible for the full EOB amount according to your insurance carrier.

SWC does not verify your benefits or check network status of our insurance with this or any lab testing services. It is the patient's responsibility to know and understand the benefit plan with their insurance carrier. If you wish to confirm network status of your insurance policy with Pathology Laboratories, they can be contacted at (419) 291-4414.

For patients with no insurance, payment for labs will be required at time of service. Pricing will be provided at the patient's request.

By signing below, you acknowledge receipt and understanding of this lab services notification.

Patients Name ____

Signature ____ **Date** ______________