Dear New Patient,

Welcome to Complementary Family Medical Care of Indiana.

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

ATTENTION NEW PATIENTS:
If you cannot keep your appointment, please notify us within 24 hours of your appointment time. We confirm all new patient appointments 24 hours in advance.

1. If you are more than 15 minutes late, you will need to reschedule your appointment.
2. Multiple no-show or late cancelled appointments may result in being discharged from our practice.
3. Please be aware that less than 24-hour notice or no-show will result in a $100 no-show fee.

Before Your Appointment:

1. Please complete new patient forms provided for you on our website; www.CompFamilyMed.com. Bring completed forms to your initial appointment.
2. YOU ARE RESPONSIBLE FOR BRINGING ALL MEDICAL/LAB RESULTS FROM PREVIOUS PROVIDERS THAT ARE PERTAINENT TO YOUR APPOINTMENT. Ask your doctor to fax all requested records to us, (317)852-6969. Please verify with their office the day before your appointment to confirm they have been faxed.
3. Please bring your drivers license and insurance cards with you to each visit.

Appointment:

1. Please arrive 15 minutes in advance for your new patient appointment.
2. If you are going to be late, please contact our office to notify us as soon as possible, (317)852-3616.

Insurance: We do NOT file Medicare, Medicaid, or any HMO plans. You may elect to submit Medicare claims to your insurance provider. All lab tests will be filed with your insurance regardless of insurance plan. 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 &
Ellie Branagin, FNP-C

Complementary Family Medical Care of Indiana

69 E. Garner Rd. Suite 300
Brownsburg, IN. 46112

Patient Consent Form

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

I hereby give my consent to **Complementary Family Medical Care of Indiana** 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 **Complementary Family Medical Care of Indiana** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Complementary Family Medical Care of Indiana** 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 **Complementary Family Medical Care of Indiana.**

With this consent, **Complementary Family Medical Care of Indiana** 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, **Complementary Family Medical Care of Indiana** 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, **Complementary Family Medical Care of Indiana** 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 **Complementary Family Medical Care of Indiana** 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 **Complementary Family Medical Care of Indiana** 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, **Complementary Family Medical Care of Indiana** 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 Complementary Family Medical Care of Indiana 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_____

Complementary Family Medical Care of Indiana

69 E. Garner Road Suite 300 Brownsburg, IN. 46112 – (317) 852-3616

Practice Policy

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 CFMC 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.

EMERGENCIES

Complementary Family Medical Care of Indiana (CFMC) is a private practice and is not designed as a crisis unit. 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) 852-3616. PLEASE NOTE: A 24 HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. THERE WILL BE A $100 CHARGE FOR APPOINTMENTS CANCELLED WITHOUR A 24 HOUR NOTICE

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**

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.

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.** Requests received from the pharmacy by 2PM will be authorized the same business day. 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 calling within 24 hours if left on a Monday thru Thursday, or on the next business day if left over the weekend. 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: REQUESTS FOR NARCOTIC REFILLS WILL ONLY BE ACCEPTED 8am-4pm, MONDAY, TUESDAY, WEDNESDAY AND FRIDAY.

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. CFMC reserves the right of check refusal.

BILLING AND INSURANCE

CFMC 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 as a result 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. CFMC 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 regards 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 CFMC. The patient must submit a written account dispute to address any specific concerns.

RELEASE OF INFORMATION

A Release of Information must be completed to allow CFMC 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 CFMC 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.

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 CFMC has referred to for treatment purposes.

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.

DOCUMENT PREPARATION

A fee of $30.00 is required for CFMC 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.

CERTAIN MEDICAL SERVICES

Some insurance companies deem certain procedures non-covered. If we feel that a service may not be covered by your insurance provider 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.

Patient Name_____Signature_____Date_____

Complementary Family Medical Care of Indiana
69 East Garner Road, suite 300
Brownsburg, IN 46112

NOTICE OF PATIENT'S FINANCIAL RESPONSIBILITY FOR ALTERNATIVE THERAPY

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

Service	Estimated Cost
Chelation 1 hour	$150
Chelation 3 hours	$165
Vitamin B12 injections	$20-$40 dosage dependent
Filling out special forms/letters	$30
Processing Fees for Specialty tests (including but not limited to: Genova, Doctors Data, Neuroscience, HDL, Boston Heart)	$40
Vitamin C for infusion	$75/25,000mg dosage depends on type of IV
Other: _____	___

The following IV therapies will be billed to your insurance provider based on the time of infusion not the product infused. Your benefits may or may not allow payment. If insurance does not pay for any reason, requests refund of previous payments, or you receive more than 1 service on the same day you will be responsible to pay in full immediately .This is in addition to cost of Vitamin C as above.

Glutathione IV	$60
Myers IV	$60
Immune/Vitamin IV	$75
Peroxide IV	$75
Cancer/Vit C IV	$115

Beneficiary Agreement:
I have been notified by Complementary Family Medical Care that the above listed services are considered alternative therapy and will not be submitted for Insurance reimbursement by CFMC, 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