Patient Agreement Form

Dr. David L. McHenry II
Phone: (520) 338-9663

What to expect

Dr. McHenry is happy to offer both in-office consultations and phone consults. However, new patients must be seen in-office for their first visit, and some in-office follow-ups may be required for refill of prescriptions.

New patient visits typically last 90 minutes, but can last up to 2 hours. Your first visit will include:

- A full medical consultation and review of systems
- Physical screening examination
- Review of records from outside physicians
- Ordering and analysis of blood work and labs
- Comprehensive treatment plan for short-term and long-term goals

Follow up appointments will be scheduled based on your particular needs. Management of chronic conditions may require monthly follow-ups, with additional visits "as needed." Whereas more acute, urgent matters will require a quicker follow up.

Policies and procedures

Setting up an appointment:

- Please call the clinic at (520) 338-9663 to schedule your appointment or if you need to speak to Dr. McHenry after your initial visit. You may also send an email to D.McHenryND@gmail.com to request a call-back for scheduling.

Cancellation Policy:

- All cancellations or rescheduling must be done over the phone, rather than email.
- New patient appointments: Because new patient visits require a large amount of time, last minute cancellations are problematic for the physician and other patients who could be seen during that time slot. Therefore, all cancellations of new patient visits must be made **48 hours prior to your appointment**.
    - Exceptions are made for true emergency situations.
    - Any late cancellation of a new patient appointment, with less than 48 hours notice, will result in a **$50 charge** to the patient.
    - No-showing a new patient appointment will result in the **full price** of the appointment being charged to the patient.
- Follow up appointments: All cancellations of follow-up appointments must be made **24 hours prior to your appointment time**. Failure to cancel with 24 hours notice, or no-showing your appointment, will result in the **full price** of the appointment being charged

to the patient. As with new patient appointments, exceptions will be made for true emergencies.

- _____ (initials) I understand that if I need to cancel or reschedule an appointment, without proper notice, I will be charged fees as outlined above.

Phone policy:

- Phone consultations will be billed the same as in-office consultations. Billing is based on the physician's time and expertise, and phone consultations require the same time and expertise as in-office visits.
- Phone consultations need to be scheduled as regular, in-person visits. Please call to schedule the phone consultation so the physician can be properly prepared for your appointment.
- _____ (initials) I give my consent for Dr. McHenry to leave voice messages at the phone number I provided. I understand that there is no guarantee that messages are private and that voicemail is not protected by HIPAA.

Emergency calls:

- Dr. McHenry is not equipped to do emergency triage. If you are experiencing a medical emergency, please call 911 or go to your nearest emergency department.
- _____ (initials) I understand that in the case of a life-threatening psychiatric or medical emergency that I will call 911 or go to the nearest emergency department.

Email policy:

- Email is not a secure form of communication and therefore, Dr. McHenry will only use email to send forms and documents. You may use email to request a call back for scheduling, but Dr. McHenry will not be responsible for material contained in emails received by patients and will not respond to such emails.
- _____ (initials) I understand emailing is not a secure form of communication and I understand that, by emailing Dr. McHenry, there is a chance that my private information is at risk.
- _____ (initials) I understand that Dr. McHenry is not responsible for reading or responding to my emails and is not responsible for any information in any emails.

Texting policy:

- Dr. McHenry does not use text messaging to communicate medical advice. Text messaging is not a secure or reliable form of communication. Dr. McHenry is not responsible for receiving, reading, or responding to any text messages. Please call the clinic number rather than texting.
- _____ (initials) I understand that Dr. McHenry is not responsible for receiving or responding to any text messages.
- _____ (initials) I understand that texting is not a secure form of communication and I understand that by attempting to text Dr. McHenry that there is a chance that my

private information is at risk, and therefore Dr. McHenry is not liable for any compromised information that occurs as a result of text messages sent.

Appointment Types:

- Follow-up appointments
    - A follow-up appointment is intended for following up on treatment, assessing any new symptoms, changes in symptoms, reviewing lab results, and adjusting treatment protocols. For any new symptoms that arise, or any additional questions or concerns, please call the clinic to be scheduled for a follow-up visit. Moreover, if you are not responding to your treatment protocol, or need additional treatment, a follow-up visit is recommended.
- Check-in appointments
    - The purpose of a check-in is to ensure that you are doing well on your protocol or to answer any clarifying questions about treatment recommendations or prescriptions. These calls are 5-10 minutes at most, and are free of charge. If more help or instruction is needed, a follow-up visit will need to be scheduled.

Fees and Services:

- New Patient Visits: $180.00
- Follow-Up Visit (45 minutes): $90.00
- Follow-Up Visit (30 minutes): $60.00
- Acupuncture Treatment (45-60 minutes each): 5 treatments for $360.00
- Hydrotherapy Treatment (45-60 minutes each): 5 treatments for $360.00
- Cupping Treatment (30 minutes): $50.00

Payment Policies:

- Payment is due at the time of service.
- Payment may be accepted in the form of cash, check, or credit card.
- Any fees accrued by bounced checks will be paid for by the patient, and Dr. McHenry has the right to refuse future payments by check. An additional fee of $15 per day will accrue until the final balance is paid off after a bounced check.
- New patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment.
- There are no refunds for any services.

Insurance:

- This clinic is “cash pay” only and does not offer services to submit your office visits to insurance. However, upon request, we will provide you with a form that you may submit to your insurance for possible reimbursement.
- Dr. McHenry cannot guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs, imaging, or prescription drugs. You are ultimately responsible for the cost of your care at our clinic.

- **Advance Beneficiary Notice (ABN):** I understand that my insurance will not be paying for any of the fees for my visits, labs, medications, or supplements under the care of Dr. McHenry. I understand that I am solely responsible for paying all balances, fees, and services accrued with the aforementioned payment methods only.
    - _____ (initials)

Privacy, Rights, Responsibilities, and Liabilities

Below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can acquire a full listing and explanation of your rights and privacy practices by going to the website at http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

You have the right to:

- Receive a notice that tells you how your health information may be used or shared.
- Ask to see and obtain a copy of your health records.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Have corrections added to your health information.
- Request where you would like to be contacted.
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with the U.S. government.
- File a complaint with your doctor.

The following is to be signed by the patient, or the person legally responsible for the patient's medical decisions relative to the treatment situation.

I, (print name) _____ (sign name) _____, hereby acknowledge that the office of Dr. McHenry provided me with access to Privacy Practices that describe how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact: http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748. By signing this, I also acknowledge that I understand that I am entitled to receive updates upon request if the office of Dr. McHenry amends or changes their Notice of Privacy Practices in a material way.

Dr. McHenry will respect your rights to privacy. However, if it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, Dr. McHenry has the obligation to disclose any relevant information.

_____ (initials) I understand that Dr. McHenry may disclose private information in circumstances where there is a threat to my health or safety, or the health and safety of another individual or the public. Therefore, I do not hold liable this doctor for disclosing private information in these circumstances.

Additionally, with the objective of personalizing and coordinating my care with other practitioners, Dr. McHenry is authorized to discuss my personal medical information with the following people:
1)_____ (phone) _____
2)_____ (phone) _____
3)_____ (phone) _____

_____ (initials) I understand that by providing the aforementioned contacts, I am authorizing my doctor to correspond with the contacts above regarding my health care.

My "in case of emergency" contact is:
1)_____ (phone)_____
2)_____ (phone) _____

_____ (initials) I am entitled to receive high quality naturopathic medical care provided by Dr. McHenry. Be informed that if your doctor needs to, that they will consult with other physicians and specialists to provide you the most quality care possible, while being compliant to HIPAA requirements.

_____ (initials) I understand that Dr. McHenry does not discriminate based on age, gender, race, ethnicity, socioeconomic status, religion, sexual orientation, or other lifestyle or cultural preferences.

_____ (initials) I understand that naturopathic medical treatments and therapies may be different from those offered by other licensed health care providers and that I am at liberty to seek other care. However, if I do choose to seek other treatments in addition to my care with Dr. McHenry, I will inform my doctor of any other treatments I am using as they may affect my care.

_____ (initials) I understand that payment is expected at the time of service, and I will pay in either cash, check, or credit card based on the rates listed above. Failure to pay at the time of service will accrue late fees of $15.00 per day.

_____ (initials) I understand that Dr. McHenry is treating me for my chief concern, based on the symptoms that I report, and/or lab-work that is ordered by Dr. McHenry. Therefore, I hold Dr. McHenry blameless if there is a condition that I have or develop that I did not report symptoms of, a history leading to, or concerns about. Such a condition therefore would be considered outside of my care with Dr. McHenry.

_____ (initials) I understand that if at any time I have a plan to hurt myself, or become suicidal or homicidal, I will immediately do the following:

- Call 911 or
- Call the National Suicide Hotline Number at 1-800-273-8255.

By signing this agreement you are indicating that you understand and agree to the terms of service explained above. You also indicate understanding of the Rights, Responsibilities, and Liabilities section explained above. By signing this agreement, you also indicate that you have given your permission to the office of Dr. David L. McHenry II to automatically charge your credit card for missed appointments, phone consultations, or any of the above stipulations that may apply to you. You retain the right to request phone consults and other services to be paid with another credit card or account at the time of service. By signing this agreement, you indicate that you understand the appropriate steps to take in an emergency situation and you agree to the terms set above.

Name of Patient or Legal Guardian: _____

Signature: _____ Date: _____