SynerGenius TELEPRESENCE

OFFICE POLICIES AND PROCEDURES

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____ 1. Failures to keep appointments hamper our efforts to be efficient and are unfair to other patients. Our office policy is therefore to charge our full fee for "no-shows" or appointments cancelled with less than 24 hours' notice. This also applies to sessions in which you are not physically located within one of our licensed states (Arizona, Colorado, New Mexico, Wyoming, Nebraska, North Dakota) at the time of your session, as these meetings will need to be rescheduled due to medical licensure laws.

____ 2. You are required to submit a current credit card for your file before scheduling your first visit. You are also required to update your credit card information as needed during your treatment so that you always maintain a valid card on file. If your card is expired or declined, or for any other reason your bill is not paid within 30 days of billing, late fees of up to 8% per year may be assessed.

____ 3. Your card on file will be charged for the full amount of your visit and any outstanding balance on the date of your appointment. You will receive a "superbill" invoice following each visit, which will include the applicable billing codes for your visit. A billing code is a string of digits or letters or both that is assigned to each diagnosis or procedure. You may submit your superbill to your insurance for any available out-of-network benefits. Please be aware, however, that the "Z codes" used for billing these integrative medicine consults are usually not covered by insurance, but may be eligible for Flexible Spending Account (FSA) or Health Savings Account (HSA) benefits, depending on your plan.

____ 4. Please submit all required paperwork and signed consent forms at least 48 hours before your first scheduled visit. If you have not returned the required paperwork by the time of your scheduled appointment, your session may be rescheduled, and you may be considered a "no-show" and billed according to our office policies and procedures.

____ 5. You will need to provide a signed release for us to communicate with both your primary care physician or other primary care provider, and your referring physician/referring provider (if they are not the same) when you submit your initial patient paperwork. The term "referring physician" or "referring provider" means the healthcare professional you are already working with, and whom you will continue to work with during and after the service our practice provides, who has made the judgment that you will likely gain additional benefit from our practice's specialty services. Of course, if your referring physician/referring provider is also your primary care physician/primary care provider, then one signed release from that professional is all that is necessary. You are responsible for letting our office know if you change primary care physicians/primary care providers and/or referring physicians/referring providers in the future and completing an updated release form.

____ 6. It is our intention to provide prompt, friendly email and telephone support to address questions or concerns you may have between visits. We are happy to respond to a limited number of email or patient portal messages at no charge. However, we do ask that you keep the volume of emails and calls within reasonable limits, in order to allow us to continue to reply in a timely fashion to all our patients. Please note that if the volume of communication becomes excessive or if this privilege is abused in any way, Dr. Heermann reserves the right to bill you for her time to address your messages at her normal hourly rate. She will discuss any concerning communication patterns with you directly before implementing this email policy.

____ 7. We are happy to complete paperwork or other letters for legal, insurance, and other reasons. We charge our normal hourly rates for such work, billed in 15 minute increments.

I, _____, have read and understand these Office Policies and Procedures, and I agree to abide by them. I have been given adequate opportunity to ask all my questions, and to all of them I have received answers satisfactory to me in language I understand. As I sign this document, I am not under the influence of alcohol or of any other drug that might impair my understanding.

Date: _____

_____
Patient Signature

_____
Patient Name (Printed)

If the patient cannot sign this form owing to incapacity, an authorized personal representative such as a guardian or a health care power of attorney should sign this document on the individual's behalf.