

The Akasha Center for Integrative Medicine

Consent, Policies and Confidentiality for Provision of Healthcare

Last Name: _____ First Name: _____

DOB: ____/____/____ SSN: ____ - ____ - ____ Today's Date; ____/____/____

Confidentiality:

The Akasha Center for Integrative Medicine and the de Mello Medical Group follow HIPPA guidelines. If you have not received a copy of the **Notice of Privacy Practices** explaining these guidelines, you may request one from our office or download one from our website: www.akashacenter.com

In addition to the **HIPPA** guidelines, we are passionate about strictly protecting the privacy of our patients. Because we strongly emphasize an integrative team approach to wellness, our practitioners regularly come together to discuss to and to assess the effectiveness of the various treatment modalities that we may employ to treat you. Please indicate below that you give us permission to discuss you care among one another

I hereby authorize the Akasha Center and the de Mello Medical Group practitioners to discuss my diagnosis and treatment options with: (Please check all that applies)

Other Akasha and de Mello Medical Group practitioners.

External practitioner (s) _____ Phone number (____) ____ - ____ E-mail: _____

I Understand that I may have my insurance claims filed on my behalf through Medical Billing Management (MBM), a billing company recommended by the Akasha Center and the de Mello Medical Group. Should I decide to utilize their services, I authorize the Akasha Center and/or the de Mello Medical Group to release information to my insurance company and to receive payment of a twenty Dollar (\$20) service charge per superbill on behalf of MBM.

Consent for Treatment:

I, _____ (Patient or parental guardian), acknowledge that _____ (Patient Name) is accepting treatment from practitioners at the Akasha Center for Integrative Medicine which may include treatment by any of the following types of practitioners: Medical Doctors (MD), Osteopathic Doctors (DO), Naturopathic Doctors (ND), Neuro-biofeedback Practitioners, Acupuncturists (L.Ac), Psychotherapists (MFT) or Massage Therapists (LMT). Akasha's doctors and practitioners may consult one another and draw upon each other's expertise in order to provide the most comprehensive care. If I am seeing the Naturopath (Dr. Maggie Ney). I understand that she does not have hospital privileges. If I need to be hospitalized, my care will be transferred to one of Akasha's medical or osteopathic physicians. I understand that, as with conventional medical treatment, there is no guarantee that complimentary and alternative therapies will offer complete resolution to any or all conditions that I may have.

Consent to Pay for Services Rendered:

I have been informed that it is my responsibility to pay in full for services rendered at the time of the patient visit. I recognize that the Akasha Center currently accepts payment via cash, personal check, American Express, Visa or Mastercard. They do not accept payment from insurance providers. I understand that at the end of the visit, I will be provided with a comprehensive invoice (superbill) of services rendered for payment and method of payment. I may submit this super bill/invoice to my insurance providers for possible reimbursement or have Medical Billing Management, a billing company recommended by the Akasha Center file on my behalf. I understand that Medical Billing Management charges a fee per each superbill they submit on my behalf and they, not the Akasha Center or de Mello Medical group are responsible for the billing services they agree to provide to you. I further understand that the Akasha Center and the de Mello Medical Group have a 48 hour cancelation policy. In order to secure my appointment I must have my credit card on file and I understand and agree that **my credit card will be charged the full amount of the visit should I miss my appointment without cancelling it within the required 48 hours.** Akasha and the Mello Medical Group offer Home visits for an additional fee based on time and distance.

Payment Fee Schedule for 2010

Comprehensive Initial Visit (One 60min Visit, one 30min follow-up Visit)
Comprehensive Initial Visit with Well Women Exam (90 Minutes)
Extended initial visit (90 Minute Visit)

Rates:

\$375/1st visit, \$225/2nd visit
\$550
\$525.00

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Follow-up 30 Minute Return Visit	\$225.00
Extended Follow up 45 minutes	\$275.00
Annual exam with pap 60 Minute Return Visit	\$450.00
IV Vitiamin drip	\$175.00
IV Vitamin push	\$125.00
Blood draw/Venipuncture	\$35.00
Phone consultation	\$125 for 15 min; \$225 for 30 min
E-mail consultation	\$45.00
Neuro-biofeedback	\$325/1 st , \$175/2 nd visit
Home visits	call to inquire

Email Consultation Policy:

It is the policy of The Akasha Center for Integrative Medicine and of the de Mello Medical Group to do email consultations under the following conditions only:

1. Only for established patients of Drs. de Mello, Gisler, Ney and Spar
2. For non-emergent issues
3. In cases where the doctor determines that an office visit is not necessary or possible
4. For clarification of on-going treatment or treatment received within the past 30 days
5. When the doctor can address the concern with a single reply, requiring 10 minutes or less
6. When the above conditions are met, and the patient has signed an informed consent of this policy.

No new health issue will be addressed by email consultation. If the doctor receives an email about a condition that in his or her opinion cannot be properly assessed without an office visit, the patient will be notified by return email to schedule an appointment, with time frame recommended. In this case, no treatment advice will be given by email. Our providers generally respond to emails within 24-48 hours, Monday through Friday only. **If you have emailed the doctor and have not received a response within these parameters, please call your doctor and leave a phone message** stating your question and/or concern. Email communication with the doctor and the doctor's reply become part of the patient's permanent record – a copy is added to the patient's medical chart. Email communication is password protected for patient privacy – no one but the doctor can access your email communication.

Phone Emergency Policy:

If an issue is emergent, dial 911 or go to the nearest emergency department. If the matter is urgent, call the office and follow the prompts to your provider's mailbox. The outgoing message will state the number at which you can reach your provider. If no reply is given in 15-20 minutes, call again. Phone calls will be returned as soon as possible. The doctor will determine if the matter should be addressed with that call, if a phone consultation should be scheduled, or if an office visit should be scheduled to address the concern. **All phone calls**, unless truly urgent or involving a simple lab reporting, will be billed at the \$50/15min rate.

Prescription Refill Policy:

I understand that if I have not been seen with in the last 3 months and if my prescribed medication requires close medical monitoring, I will be charged \$35.00 (Thirsty five Dollars) for the administrative cost related to calling, faxing or mailing any of your prescriptions. To avoid these charges, please present all of your prescription requests at the time of your visit

Our Director of Wellness Integration and Your Satisfaction:

The Akasha Center for Integrative Medicine and the de Mello Medical group are very committed to fulfilling our vision of medicine while providing you with the best healthcare possible. We want you to be satisfied with our care. Therefore, should you encounter any difficulty contacting any of our practitioners or the front office staff, please contact our Director of Wellness Integration, Kirsten Welles, Lac at kwelles@akashacenter.com or call her at (310) 892-6431. She will make sure your questions and concerns are promptly addressed. **For Questions regarding your insurance reimbursement filled on your behalf by The Billing Management company, please contact them directly at (310) 694-5400**

I, _____ (Patient or Parent/Guardian Name), have read and agree to the above policies of the private practices of The Akasha Center for Integrative and the de Mello Medical Group

Patient or Parent/Guardian Signature: _____ **Date:** ____ / ____ / ____
Doctor's Signature: _____ **Date:** ____ / ____ / ____