Marin Optimal Health
Sara Kendall Gordon, L. Ac. DAOM

PATIENT AGREEMENT & GENERAL OFFICE POLICIES

This agreement is designed to familiarize you with our office policies. Please **READ** and **INITIAL** after each paragraph were indicated. Your initials indicate that you have read the statement. After completing all pages SIGN this document and be assured that you will be receiving the very best care available.

Doctor/Patient Communication:
Communication is essential. All questions, comments, and suggestions are welcome. If you have a new illness or injury, please call to schedule and examination. You may call the office at any time with any questions, comments or concerns. (Please do not send emails.) We check voice mails frequently, Mondays through Fridays, from 9:00am and 5:00pm, and we return telephone calls as soon as possible (except during holidays).

Initials_____

PAYMENT POLICY
Payment is expected at the time services are rendered.
Initials_____

Non-Insured or Patient With No Coverage in Our Office
In an effort to reduce paper if you need a statement for tax or bookkeeping purposes, upon request we will provide an itemized statement at the end of the calendar year. If you need a statement to submit to your HSA, Flexible Spending Account, or cafeteria plan we will provide you with an itemized statement at the time of your visit.
Initials_____

Health Insurance With Out-of-Network Benefits
Payment is expected at the time services are rendered.
We will submit your claims electronically on a weekly basis. Electronic claims are usually processed within 10-30 days by your carrier. If your carrier doesn't accept electronic claims we will provide you with a superbill that you can submit to your carrier for processing.

This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

If you would like for us to submit your claims for you, please complete this section and we will need to make a copy of your current insurance identification card:
Insured's Name_____ Insured's Date of Birth_____
Insured's Relationship To The Patient ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insured's Address_____ City_____ State_____ Zip Code_____
Insured's Phone Number (_____) _____-_____

Insurance Carrier's Name_____
Insured/Subscriber's ID Number_____, Group/Plan/Policy Number_____
Carrier's Address_____ City_____ State_____ Zip Code_____
Carrier's Phone Number (_____) _____-_____

Please sign the following statement which authorize us to release information about you to your carrier should they request it: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process my claims.
Signature_____ Date_____

Initials_____

PATIENT AGREEMENT & GENERAL OFFICE POLICIES (Continued)

Medicare
Doesn't cover acupuncture or nutritional work in this office and therefore all services need to be paid for in full at the time of service.

Initials_____

Medi-Cal
If you are a **Medi-Cal** patient, please note that we are not a Medi-Cal provider and therefore all service need to be paid for in full at the time of service.
Initials_____

Workers' Compensation:
Because we are a "cash" practice we do not treat work related injuries. If you are injured on the job, please contact your employer for a referral.
Initials_____

Personal Injury (Liability Claims)
If you have been involved in a slip or fall injury or automobile accident you are required to pay for each visit in full at the time of service and we will provide you with a superbill that you can submit to your automobile carrier, attorney, or other insurance carrier.
Initials_____

Rescheduling Appointments:
If you find it necessary to reschedule an appointment, please give us 24 hour- notice. You may call us 24/7 and leave a message on our confidential voice mail or stop by during office hours and we will reserve a new time and/or day so that you don't miss any of the care necessary to help you move towards your desired outcome. If you do not provide us with 24 hours-notice you will be charged the full fee for the appointment that was missed. If you miss an appointment it should be reschedule for later that day if possible. If you are unable to reschedule for the same day, we will do our best to reschedule your appointment on our next business day. All schedule appointments are necessary! If we are able to fill your appointment there will be no charge.
Initials_____

Fees:
Complexity is established by Dr. Gordon using her professional expertise and current professional coding guidelines.

- The fees for a thorough history and examination range from $120-$160.00 depending on the complexity of your case.
- Acupuncture sessions ranges from $80 to $120 per visit depending on the length of your visit.
- Nutritional sessions range from $80-$120 per visit depending on the complexity of your case.
- Brief visits to our pharmacy for acute care which involve answering one or two questions is $40.00.
- Emails will be returned during business hours and there may be a charge (??????)
- Telephone appointment can be scheduled with the front desk. Fees range from $40-120 depending on the length of the phone call.
- There will be additional charges for any physical medicine and rehabilitation services and for nutritional supplements.

Initials_____

Returned Product
In order to receive a credit for returned items, they must be returned within one month of the purchase date and must not be expired or damaged and the seals must not have be broken. There is a $7.50 restocking fee per item.
Initials_____

PATIENT AGREEMENT & GENERAL OFFICE POLICIES (Continued)

Drop Shipment Policy
If we are ordering products that will be sent directly to your home, it is important that we have your currently mailing/shipping address. The office is not responsible for any items lost during the drop ship processing. Payment is required at the time the order is placed.
Initials_____

Refills
If you need a refill please let us know as soon as possible so that we have it available for you on your next visit. If you need it prior to your next visit we will set it aside for you for pick-up at the office during regular office hours. If it is not picked-up within seven days we will reshelf it so that it is available for someone else that may need it.
Initials_____

Special Orders
If are interested in making a special order for a product that we don't carry, you will need to schedule a 15 minute consultation with Dr. Sara for determine if the product will be safe, effective and necessary. Payment will be required at the time of service and are not refundable.
Initials_____

Lab Results
Many of the laboratory tests ordered are complex and are integral to diagnosis complex conditions. Because of this, Lab results will only be discussed during office visits. Results will not be available until you have an opportunity to discuss the findings with Dr. Sara.
Initials_____

Methods of Payment:
The forms of payment we accept are: Cash, Check, MasterCard, and Visa.
Initials_____

Notice of Privacy Practices
Our policy is posted in our reception area and our or website www.marinoptimalhealth.com. It is available for viewing 24/7. I have am aware that I have access to this information and have been provided access to this notice and am aware of my rights to privacy.
Initials_____

Special Announcements
Our office uses an online service provider to notify patients of special events and offers.
Please indicate below if we you would like to receive notices using this resource.

☐ Yes, I give my permission for Dr. Sara Kendall Gordon, L.Ac. DAOM to send me email notifications via her on-line service provider regarding specials, events, classes or other announcements related to her practice.

☐ No, please do not send me any email notifications using on-line service providers.
Initials_____

PATIENT AGREEMENT & GENERAL OFFICE POLICIES (Continued)

(A copy of this form can be provided upon request.)

CONSENT FOR TREATMENT AND CARE
I, the undersigned, do hereby request and consent to the performance of **Acupuncture** and **Oriental Medicine procedures.**

The methods of treatment may include, but are not limited to, **acupuncture, electrical stimulation, low-level laser therapy, massage, Chinese** or **Western herbal medicine,** and **nutritional counseling**. I've been informed that acupuncture is a **safe** method of treatment, but in a very rare instance, there may be some bruising or tingling near the needling sites that may last a few days. The herbs and nutritional supplements used are considered safe according to the standards of Western and Oriental Medicine.

I wish to rely on Dr. Gordon's **professional judgment** during the course of treatment, knowing that she will always work in my best interests.

By signing below, I agree to the above named procedures. I intend this consent to cover the **entire course of treatment** for my personal condition(s). The statements I made on this form are correct and complete to the best of my knowledge.

_____ _____
Patient or Parent / Guardian Signature Date

_____
Print Name of Patient and / or Name of Signature