DEMOGRAPHIC INFORMATION

Patient's Full Name: _____
Date of Birth: ____/____/_____ Age: _____ Social Security # _____
Sex: male female
single married divorced other

Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Cell: _____ Email: _____

Employer: _____ Telephone:_____
Occupation/Job Description: _____
Work Address: _____

Spouse: _____ Date of Birth: ___/___/_____ Social Security # _____

Person to contact in case of emergency: _____
Relationship to patient: _____ Telephone: _____

Preferred method of contact (Please check all that apply): Cell Home Email Work

Who referred you to this Practice? _____

INSURANCE INFORMATION

Primary Insurance**:** _____
Claims Address**:** _____
City: _____ State: _____ Zip: _____ Telephone: _____
Name of Guarantor: _____ Relationship: _____
Guarantor's Date of Birth: _____
Policy # _____ Group # _____
Guarantor's Employer:_____ Telepone:_____
Guarantor's Job Description: _____

Secondary Insurance: _____
Claims Address: _____
City: _____ State: _____ Zip: _____ Telephone: _____
Name of Guarantor: _____ Relationship: _____
Guarantor's Date of Birth: _____
Policy # _____ Group # _____
Guarantor's Employer:_____ Telepone:_____
Guarantor's Job Description: _____

Patient's Signature: _____ Date:_____

CONSENT FOR RELEASE OF INFORMATION

Federal law (HIPAA) requires that we obtain your consent before disclosing any medical information to other individuals. Please tell us whom you allow us to speak with in regards to your medical condition.

I, _____, hereby authorize the medical providers
(Print Patient's Name)
and staff of Modern Medical & Wellness to discuss my medical condition, diagnoses, tests, treatment, and prognosis, with the following individuals upon request:

INDIVIDUAL	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____
_____	_____

This authorization will remain in effect until revoked in writing by me.

_____ _____
(Signature of Patient) *(Date)*

_____ _____
(Signature of Parent or Legal Guardian) *(Relationship)*

AUTHORIZATION TO LEAVE MESSAGES REGARDING HEALTH INFORMATION

☐ *Please leave me messages on my voicemail regarding my health information.*

☐ *Please leave me messages on my email regarding my health information.*

☐ *Please leave me text messages on my cell phone regarding my health information.*

☐ *All of the above are okay.*

INSURANCE ASSIGNMENT OF BENEFITS

I hereby appoint as my authorized representative, and assign to, Modern Medical & Wellness all my right, title, and interest in and to, and relating in and to recovery of, any and all health care and/or surgical benefits otherwise payable to me or to which I am entitled for medical treatment, including major medical, rendered by Modern Medical &Wellness.

I also specifically authorize my authorized representative to do the following on my behalf:

1. File and prosecute any required appeal or grievance with my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative.
2. File any required complaint, appeal or grievance with the state insurance department, Department of Labor, or any other regulatory agency for payment of medical claims submitted by or on behalf of my authorized representative.
3. File any required litigation or arbitration against my health plan and/or health insurer for payment of medical claims submitted by or on behalf of my authorized representative and to exert or receive any other rights or benefits under my health plan with respect to the treatment rendered by Modern Medical & Wellness and I specifically authorize my authorized representative to name me and the patient, if I am executing this document on the patient's behalf, as plaintiffs in such litigation to name me and the patient, if I am executing this document on the patient's behalf, as plaintiffs in such litigation or arbitration against my health plan and/or health insurer or otherwise pursue claims on my behalf. I hereby also assign to Modern Medical & Wellness any right to recover its full billed charges and any expenses and fees incurred for pursuing the claim, as well as all rights, statutory or contractual, to any additional recovery related to my health benefits such as treble damages, punitive damages and/or penalties.
4. Discuss my personal health information with my health plan/ or health insurer.
5. I specifically authorize any law firm appointed to any or all of the items listed above.

I hereby certify that all the information given on this form is complete and accurate to the best of my knowledge. In the event of default on payment of charges, I agree to pay collection fees including reasonable attorney fees.

_____ _____

(Signature of Patient) *(Date)*

_____ _____

(Signature of Parent or Legal Guardian) *(Relationship)*

OFFICE POLICIES VERSION 1.12

The following policies are designed to give you the best experience possible when contacting us at MMW between visits. We want our communications with you to be easy and efficient. We usually return calls, emails and faxes between 24-72 hours. Website: http://modernmedicalandwellness.com/.

We answer our phones from 9:00 am until 5:00 pm, Tuesday through Friday. However, the medical providers are with patients during the day potentially causing them to be unable to speak with you directly at the time of your call. Our clerical and clinical staff will do their best to answer quick questions, but a more complex one may require a phone consultation with the medical provider.

CONTACTING US DURING NON-BUSINESS HOURS

- If you have a true emergency call 911. However, if your concern is not urgent, we ask that you wait until normal business hours to call or leave a message for our office staff.

SCHEDULING

- You will get an electronic reminder (email & text) when the appointment has been created, and 24 hours prior. If you are not receiving them, notify a staff member and they will assist you. This is a courtesy.
- During the medical visit the Medical Provider will attend to the condition that is scheduled for only. If there is another condition that you would like addressed we will need to reschedule you for a seperate office visit, so that the Medical Provider may provide care to every Patient on schedule timely. Otherwise please note, if the time exceeds past the allowed appointment tjere will be an "Extended time" fee charged and/or billed which most insurances are not covering and thus would require payment in full at time of service.

NO SHOW/LESS THAN 48 HOUR CANCELLATION

- In order to provide better service to our patients, we do not overbook to compensate for no shows and late cancellations. Should you need to change or cancel an appointment or procedure for Modern Medical & Wellness, please contact us 48 hours before your scheduled appointment, via electronic reminders, email, or voicemail. Any cancellations with less than 48 hours notice will result in full charges billed to your credit card on file.
- You will receive multiple reminders in the form of a text message as well as email. We do ask that you give us a call to confirm your appointment and if possible confirm the reason for the appointment also, i.e. medical issue, diet, etc. the importance of this is each reason to be seen by the doctor has time standards attached to it, if you come in for one reason and the appointment has to be extended for a separate diagnostic reason additional charges will be added for the extended time and diagnostic exam(s).
- If you're late for your appointment you will be seen for the remainder of your appointment time in order to avoid delays. If you are more than fifteen minutes late for your appointment, <u>you will be charged for the additional time spent with the doctor</u>, we bill in increments of 1-14 mins. $225.00 for new patient appointments, and $125.00 for established. Each additional increment of 1-14 min will be an additional $125.00 Please be sure to review our office fee schedule.

PRESCRIPTION REFILLS

- We will fill prescriptions during regular business office hours (9:00 am- 5:00 pm). We ask that you have your pharmacy fax a refill request to us @ 702-242-8600 or you may fax it yourself. Decisions can take up to 4 business days. We ask that you do not use our afterhours answering service for prescription refills. Unless it is an emergency and you have used the exhaused all other options to avoid duplicates/delays.

Initials: _____

MEDICAL POLICIES

- We will copy or fax your records upon request. There is a $0.60 per page copy fee for medical records. You must sign a medical release form and pay the copying fees before records are sent out.
- All lab orders and results are reviewed and discussed during appointment times for legal documentation per state law.
- The medical providers are available for phone consultations for the convenience of our patients who live out of town or have schedules which do not permit them to come in for office visits. If you request to speak with doctor by phone for any reason your account will be billed accordingly for time spent on the phone.
- It is highly recommended that patients call the office before coming in to pickup supplements, test weigh ins, etc. please be patient with our staff, as we try to be respectful of scheduled appointments, they will be a priority.

FINANCIAL POLICIES

- We require a valid, current credit card to be on file for you to make an appointment. We will bill your insurance with the information you provided. However, you are ultimately responsible for payment on your treatment received. Balances from your Explanation of Benefits that are your responsibility with be processed to your credit card on file. The Nevada Prompt Pay Statute (section 6908.012) requires that claims be either paid or denied by insurance carrier within 30 days of receipt of claim. If your insurance carrier has not appropriately paid the submitted claim within 30 days, you will be responsible for the outstanding balances. **Statements and Invoices will be emailed unless you request in writing to send via mail.**
- All fees are due at time services are received, including but not limited to co-pay, co-insurance, deductible, non covered services, and cash pay services.
- Modern Medical and Wellness is contracted with many insurance carriers and may be required to submit claims for medical services for patients covered under these contracts.
- For your convenience, we will submit claims to insurance carriers to whom we are not network providers, but the responsibility, for payment of all services provided by Modern Medical and Wellness remains with you, the patient.
- In the event of a claim denial of coverage from your insurance carrier, all charges are your financial responsibility. Ultimately you are responsible for all services and their respective fees incurred at Modern Medical & Wellness regardless if you are self pay or insurance.
- Be advised, the staff of Modern Medical & Wellness will not change procedure or diagnosis codes in order to obtain payment unless it is valid and lawful.
- Your insurance will not pay for all services of your health care costs. It is your responsibility to know your covered health benefits. When testing is ordered, we will not know if the service will be covered by your insurance. While some insurers do not require such, when obtained, a pre- authorization is not a guarantee of payment. We require a signed Advanced Beneficiary Notice (ABN) or Confession of Judgment (COJ) for all in-office procedures and testing. Without you signing an ABN and/or COJ, we will not perform the offered service.
- If the amount charged to your credit is denied, a $15.00 declined credit card charge will be incurred. If you dispute your credit card charge through your credit card company/bank that was authorized by you an administrative dispute fee of $75.00 will be added to your account regardless of the outcome. Please ensure your credit card information is accurate when you come into the office.
- If there are billing errors, you may have them addressed by submitting a request in writing to: mmwbilling@gmail.com
- All services and product sales are final, no refund will be issued. Patients are responsible for payments for services and labs preformed. No refund will be given once a service has been provided or lab test has been purchases and taken from the office. There is a $35.00 fee for returned checks. This fee is what our bank charges us, we cannot be credited back for it; please do not ask us to credit your account back. We all make mistakes, and while we understand, our bank does not. The credit card on file will be billed for the amount of the returned check plus any attorney or collection/small claims court associated fees.

Initials: _____

- If you choose to be seen by Modern Medical and Wellness, you must pay all outstanding fees and current charges up front, before you can be seen. Additionally, should Modern Medical and Wellness have to take this action in order to obtain payment for services we have already provided to you, it will result in your discharge from the practice.

- For whatever reason if your account should go through internal collections, be turned over to a collection agency, attorney, or processed by the office through small claims court, and/ or you fail to fulfill your financial obligations within 30 days, your account will be subject to $25.00 monthly late fees, 20% annual interest, and 33% collection fee of the original balance in the event this is turned over to a third party collection agency which includes all fees, and or court costs, etc. Collection court adminstration fee may be applied. In the event your debt is processed for third party collections a one time doc. prep fee of $150.00 will be charged.

NON-DISCRIMINATION POLICY

- Modern Medical and Wellness does not discriminate in the delivery of health care services based on race, ethnicity, national origin, religion, age, sex, mental and physical disabilities, sexual orientation, genetic information, or source of payment.

Patient Signature:_____

Print Name: _____

Date of Birth: _____

Date: _____

Modern Medical & Wellness
911 N. Buffalo Dr., Ste. 113
Las Vegas, NV 89128
Tel: (702) 987-1555
Fax: (702) **242-8600**

Medical Records Request Form

Date: _____

To: _____ Phone: _____
_____ Fax: _____
_____

I hereby authorize and request that my complete medical history records that you have in your possession, including all Illnesses, Treatment, Lab Results, Prescriptions, X-rays and MRIs be released to:

Modern Medical & Wellness
911. N Buffalo Dr.#113
Las Vegas, NV 89128
Phone: (702) 987-1555 **Fax:**
(702) 242-8600

☒ All records requested unless otherwise specified_____

Patient Details:

Patient Name: _____

Street Address: _____Apt. #:_____

City: _____State:_____ Zip: _____

Phone: _____SSN:_____DOB:_____

_____ _____
Patient's authorized signature: Date:

TODAYS DATE: _____

NEW PATIENT HISTORY AND PHYSICAL FORM

CHIEF COMPLAINT(WHAT IS YOUR GOAL FOR TODAYS VISIT) _____

_____

_____

_____

HISTORY OF PRESENT ILLNESS

- *Location* of pain/problem? _____
- *How long* have you had this problem? _____
- How did the problem *start*? _____
- How *often* do you have the pain? _____
- What makes it *worse*? _____
- What makes it *better*? _____
- What *associated problems* have you been having? _____
- What does the pain feel like? (throbbing, shooting, sharp etc) _____

- What is the *severity* of your pain? Circle the appropriate number below:

(No Pain) **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** (Extreme Pain)

GENERAL MEDICAL INFORMATION

Who is your Family Doctor? _____ Date of last visit: _____

My general health is: (Please circle one) Fair Excellent Very Good Good

Are you pregnant or attempting to get pregnant? YES NO

List medications and/or foods that you are *ALLERGIC* to or have had a bad reaction to: _____

What kind of reaction did you have? _____

PREFERRED PHARMACY

PREFERRED PHARMACY: _____ PHONE NUMBER:_____

ADDRESS: _____ FAX NUMBER: _____

CURRENT MEDICATIONS

List any medications you are currently taking including strength and how often taken:

Name	**Dosage**	**How Often**

SUPPLEMENT AND WEIGHT MANAGEMENT DRUGS

Are you currently taking (or have you taken in the past) diet pills or herbal supplements? Yes No

If yes, write name of the pill/ supplement and date last taken:

Name	**Last Taken**

PAST MEDICAL HISTORY

Check any problem you have ever been treated for:

- ☐ Arthritis
- ☐ Hypertension
- ☐ Sickle Cell Anemia
- ☐ Cancer
- ☐ Lupus
- ☐ Heart Attack
- ☐ Blood Transfusion
- ☐ Hereditary Defects
- ☐ Rheumatoid Arthritis
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ Cataracts
- ☐ Osteoporosis
- ☐ Heart Murmur
- ☐ Cirrhosis
- ☐ Glaucoma
- ☐ Brittle Bones
- ☐ Peripheral Vascular Disease
- ☐ HIV/ AIDS
- ☐ Drug Dependency
- ☐ Ruptured Disc
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Head Injury
- ☐ Sciatica
- ☐ Blood Clots
- ☐ Gout
- ☐ Convulsions
- ☐ Spinal Curvature
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Fainting Spells
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Insomnia
- ☐ Stomach Ulcers
- ☐ Bladder Infection
- ☐ Emphysema
- ☐ **NO PROBLEMS**

Other:

_____

_____

_____

_____

SURGICAL/ HOSPITALIZATION HISTORY

PRIOR SURGERIES

Type of Surgery	Date of Surgery

PRIOR NON- SURGICAL HOSPITALIZATION, MAJOR ILLNESSES OR INJURIES

Reason for Admission	Date of Admission

SOCIAL HISTORY

Occupation: _____ Marital Status: S M W Div Sep
Are you working now? _____ If no, when did you work last? _____
Place of Birth: _____ Highest Level of education: _____

I live:

☐ Alone ☐ w/Spouse ☐ w/Parents ☐ w/Children ☐ Other

Do you smoke or use tobacco products?	No	Yes	Packs per day _____ _____Years _____
Do you drink alcohol?	No	Yes	How much? _____
Do you recreational drugs?	No	Yes	Which drugs?_____
Do you exercise?	No	Yes	How often? _____ _____
Are you taking birth control?	No	Yes	Method _____

FAMILY HISTORY

Mother: Living: YES NO Age: _____ Condition of health: _____
If deceased, cause of death and age at death: _____

Father: Living: YES NO Age: _____ Condition of health: _____
If deceased, cause of death and age at death: _____

Have you or any member of your family ever had?

Indicate relative by placing a letter next to problem

F- (father)**, M-**(mother)**, GF-**(grandfather)**,GM-** (grandmother), **B-**(brother)**, S-**(sister)**, C-**(child)**, U**-(uncle)**, A-**(aunt)

- ☐ CANCER
- ☐ HEART ATTACK
- ☐ ARTHIRITS
- ☐ KIDNEY PROBLEMS
- ☐ EMPHYSEMA
- ☐ HIV/AIDS
- ☐ LUNG PROBLEMS
- ☐ ULCERS
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES
- ☐ SEIZURES
- ☐ HEPATITIS
- ☐ COPD
- ☐ OSTEOPOROSIS
- ☐ BACK INJURY
- ☐ DEPRESSION
- ☐ HEART DISEASE
- ☐ STROKE
- ☐ TUBERCULOSIS (TB)
- ☐ ASTHMA
- ☐ LUPUS
- ☐ REACTION TO ANESTHESIA
- ☐ STOMACH PROBLEMS
- ☐ SKIN BREAKDOWN
- ☐ **NO PROBLEMS**

SYMPTOM/SYMPTOMS REVIEW

If you have ever experienced any of the following problems, please mark the box to the left and write the year you experienced it right.

GENERAL HEATLH/ CONSTITUTIONAL SYMPTOMS

- ☐ FATIGUE
- ☐ DIFFICULTY SLEEPING
- ☐ UNEXPLAINED BLEEDING
- ☐ FEVER/CHILLS
- ☐ NIGHT SWEATS
- ☐ RECENT WEIGHT CHANGE
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

EARS / NOSE / THROAT / MOUTH

- ☐ EARACHES OR DRAINAGE
- ☐ BAD BREATH OR BAD TASTE
- ☐ BLEEDING GUMS
- ☐ HEARING LOSS
- ☐ MOUTH SORES/ULCERS
- ☐ FREQUENT SORE THROAT
- ☐ RINGING IN THE EARS
- ☐ DIFFICULTY SWALLOWING
- ☐ VOICE CHANGES
- ☐ SINUS INFECTION/PROBLEM
- ☐ SINUS TENDERNESS
- ☐ DRYNESS OF THE MOUTH
- ☐ NOSE BLEEDS
- ☐ HAY FEVER
- ☐ DENTURES
- ☐ OTHER_____
- ☐ **NO PROBLEMS**

CHEST/BREAST

- ☐ BREAST DISCHARGE
- ☐ BREAST IMPLANTS
- ☐ BREAST LUMP
- ☐ BREAST PAIN
- ☐ OTHER _____
- ☐ **NO PROBLEM**

CARDIOVASCULAR

- ☐ CHEST PAIN OR PRESSURE
- ☐ BLOOD CLOTS
- ☐ SWELLING OF FEET AND/OR ANKLES
- ☐ FAST OR IRREGULAR HEART BEAT
- ☐ PALPITATIONS
- ☐ SWELLING OF THE HANDS
- ☐ HEART TROUBLE
- ☐ LEG CRAMPS
- ☐ POOR CIRCULATION
- ☐ OTHER_____
- ☐ **NO PROBLEMS**

HEAD/FACE

- ☐ HEADACHES
- ☐ LESIONS OR SCARS
- ☐ REDUCED FACIAL STRENGTH
- ☐ RECENT HAIR LOSS
- ☐ MASSES
- ☐ FACIAL PARALYSIS
- ☐ SCALP TENDERNESS
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

NECK

- ☐ MASSES
- ☐ TENDERNESS
- ☐ THYROID TENDERNESS
- ☐ VEIN DISTENTION
- ☐ SWOLLEN GLANDS IN THE NECK
- ☐ PAIN
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

RESPIRATORY

- ☐ WHEEZING
- ☐ CHRONIC OR FREQUENT COUGHS
- ☐ COUGH WITH MUCOUS PRODUCTION
- ☐ DIFFICULTY BREATHING
- ☐ DRY COUGH
- ☐ SHORTNESS OF BREATH WHEN LYING FLAT
- ☐ SHORTNESS OF BREATH WHEN WALKING
- ☐ PAIN WHILE BREATHING
- ☐ SPITTING/COUGHING BLOOD
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

GASTROINTESTINAL

- ☐ HEARTBURN OR INDIGESTION
- ☐ CHANGES IN BOWEL MOVEMENTS
- ☐ RECTAL BLEEDING OR BLOOD IN STOOL
- ☐ PAINFUL BOWEL MOVEMENTS
- ☐ CONSTIPATION
- ☐ LOSS OF APPETITE
- ☐ NAUSEA OR VOMITING
- ☐ ABDOMINAL PAIN
- ☐ FREQUENT DIARRHEA
- ☐ STOMACH PAIN OR CRAMPS
- ☐ OTHERS _____
- ☐ **NO PROBLEMS**

LYMPATIC / HEMATOLOGIC

- ☐ BLEEDING OR BRUISING TENDENCY
- ☐ ENLARGED GLANDS
- ☐ PHLEBITIS
- ☐ SLOW TO HEAL AFTER CUTS
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

NEUROLOGICAL / PSYCHIATRIC

- ☐ CONVULSIONS OR SEIZURES
- ☐ FREQUENT/RECURRING HEADACHES
- ☐ NUMBNESS OR TINLGING SENSATION
- ☐ TREMORS
- ☐ MEMORY LOSS OR CONFUSION
- ☐ LIGHT HEADEDNESS
- ☐ LOSS OF CONSCIOUSNESS
- ☐ FEELING BLUE OR SAD
- ☐ DIZZINESS
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

GENITOURINARY

- ☐ BURNING OR PAINFUL URINATION
- ☐ BLOOD OR PUS IN URINE
- ☐ VAGINAL DISCHARGE
- ☐ INCONTINENCE OR DRIBBLING
- ☐ PAIN WITH PERIODS
- ☐ SEXUAL DIFFICULTY
- ☐ GENITAL RASH OR ULCERS
- ☐ IRREGULAR PERIODS
- ☐ TESTICULAR PAIN
- ☐ CHANGE IN FORCE OR STRAIN WHEN URINATING
- ☐ PROSTATE PROBLEMS
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

MUSULOSKELETAL / EXTEMETIES

- ☐ BACK PAIN
- ☐ COLD EXTREMETIES
- ☐ DIFFICULTY CLIMBING STAIRS
- ☐ DIFFICULTY WALKING
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS OR SWELLING
- ☐ NUMBNESS OR TINGLING
- ☐ PARALYSIS
- ☐ WALK WITH A LIMP
- ☐ WALK WITH ASSISTIVE DEVICE
- ☐ WALK ONLY LIMITED DISTANCES
- ☐ WEAKNESS OF MUSCLES OR JOINTS
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

INTEGUMENTARY / SKIN

- ☐ CHANGE IN SKIN COLOR
- ☐ CHANGE IN HAIR OR NAILS
- ☐ PSORIASIS
- ☐ RASH OR ITCHING
- ☐ SKIN NODULES OR BUMPS
- ☐ SKIN CHANGES AFTER SUN EXPOSURE
- ☐ OTHER _____
- ☐ **NO PROBLEMS**

PLEASE LIST OTHER PERTINENT INFORMATION YOUR MEDICAL PROVIDER SHOULD KNOW:

_____

_____

_____

I hereby attest that I personally completed this History and Physical form and all the information is true and correct.

_____ _____

Signature of Patient or Guardian completing form **Date**

Office Staff:

HISTORY FORM REVIEWED BY: _____ DATE: _____

HISTORY FORM REVIEWED BY: _____ DATE: _____

PATIENT SELECTION OF LAB/ RADIOLOGY VENDOR

To our valued patients:

Although we try our best to get your labs/ radiology orders processed at the correct facility as directed by your insurance carrier, it is your responsibility to inform us to what lab your insurance company recommends we use for the processing of your medical orders. Please be sure to inform us during your scheduled appointment to which vendor that you prefer. Failure to do so may result in you being responsible for additional payments that would not be necessary if you had given us the correct information and gone to an in-network vendor.

Correct lab/ Radiology: _____

Print Name: _____

Signature: _____

Date: _____

Note: If you do not indicate a lab and it goes to the wrong lab, we DO NOT accept financial responsibility for any bills you incur as a result of the specimen being processed by an out-of-network or non-contracted lab facility with you insurance carrier. You are responsible for your medical services.

APPOINTMENT POLICY

To those patients that have elected to have a valid cc on file, appointment may be made with the understanding that 48 hours notice must be given to change or cancel these appointments. We consider each appointment a reservation of your time as well as clinic staffing. We are a small clinic that will continue to provide high quality, VIP service without additional costs or membership fees. To do this, we ask for a financial commitment for all appointments scheduled.

If you are still uncomfortable with leaving your credit card on file (security encrypted), may we suggest the utilization of prepayment for your visits and services in the form of cash, card, or check for the amount of $75.00. You will not be scheduled an appointment if you refuse to make a reservation with prepayment or credit card on file, to hold your reservation.

Our commitment to security extends not only to your privacy with medical records (HIPAA) and also your financial data is protected.

When you schedule an appointment you will be given electronic reminders, usually when you make your appointment and 24 hours prior to your appointment. Please confirm your appointments or they will be cancelled. (No response= Cancellation by Clinic)

I, _____ authorize Modern Medical & Wellness to charge my credit card for the amount of $75.00 in the event that I NO SHOW or cancel my appointment WITHOUT a 48-hour notice.

Credit Card Number	
Expiration Date	**CVV**
ACH: Bank Account_____	**Routing #:**

Billing Name
Billing Address
City
Zip Code
Billing Phone Number

I _____ Decline to leave my credit card on file, and I acknowlege that I will be seen on a walk in basis, and scheduled appointments will be treated first.

I have read the above statement and agree with terms and conditions.

Patient Name

Patient Signature **Date**

Office Staff: (please initial)

Alert created in prognocis? YES_____ NO_____