OPTIMAL HEALTH DIMENSION

TELEPHONE CONTACT FORM FOR THE PROSPECTIVE PATIENT

The following information has to be completed for each prospective patient scheduled to be seen as a new patient for this practice.

Prospective Patient (PP) Name: _____ Today's Date: _____

Parent/Legal Guardian's Name: _____ Date of Birth (PP): _____

Address: _____ ☐ Male ☐ Female

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email: _____ Fax #: _____ D.Lic. #: _____

Referred By: _____

Diagnosis or Reason for Visit: _____

Day, Date & Time of Appointments: 1st (ASAP): _____ Provider: _____

2nd(2 wks later): _____ Provider: _____

3rd(4 wks later): _____ Provider: _____

Credit Card #: _____ Exp. Date: _____ Sec. Code: _____

**** CC types – Amex always starts with 3 (11 digits), Disc. - 6011/6 (16 digits), Visa - 4 (16 digits) , MC - 5 (16 digits)**

Amount Charged: _____ Staff Name: _____ Staff Initial: _____

Please note all office policies and procedures to and initial each statement below as you agree to the policies: All boxes must be initialed.

Thank you for your interest in our unique practice. Our goal is to help you with your journey towards achieving optimal health. We are looking forward to meeting you. A few practice policies you should know about include:

_____ All prospective patients are usually seen for the first visit by one of the healthcare providers (MD/DO/NP) to initiate evaluation and diagnostic work-up.

_____ A credit card deposit of $200 is required to secure a new patient appointment. This deposit will be forfeited if the prospective patient does not show up for the appointment. This deposit is only refundable if a 72-hour cancellation notice is given. The deposit can be used to secure another one-time **new patient appointment** if a 72-hour cancellation notice was given. All cancellations are to be made by **speaking to a staff member** and not by voicemail, email, or fax.

_____ Optimal Health Dimensions and its medical staff do not participate with any commercial insurance plan, Medicare or Medicaid. All services provided by this practice are strictly a fee-for-service. Payment is due at the time of service. Every patient is provided an **invoice** stating services rendered charges and payments and patient diagnosis, which then can be forwarded by the patient to his/her insurance to seek reimbursement.

_____ **Reimbursement for services rendered by this office is determined by one's health insurance plan and is not determined by the practice. Reimbursements are lower than office charges.**

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_____ Many of the healthcare services provided by this practice are considered elective or alternative medicine and therefore may not be covered by health insurance plans and may not be reimbursable.

_____ The providers do not admit or provide services in any hospitals, nor after-hour services.

_____ All patients are required to have their own PCPs at the time they start with our practice since our providers do not operate as primary care providers (PCP).

_____ All in-state and especially out-of-state prospective patients must be willing to follow up for all requested and scheduled appointments to discuss their healthcare issues even if it means coming in on a weekly basis or additional unexpected visits. Excuses of transportation problems or distance are not acceptable. By agreeing to become a patient in our practice, prospective patient agrees to meet their obligation of keeping all office visits at a frequency determined by the providers.

_____ Phone consults are discouraged.

_____ The practice does not provide services for Worker's Compensation assessments. These should be managed by the patient's PCP.

_____ In addition to local medical laboratories, this practice uses other laboratories – in-state and out-of-state to assist in diagnosing of the patient. Many of these laboratories do not participate with any health insurance plans and therefore, operate on a fee-for-service basis. Reimbursement for their services by one's health insurance plan may therefore, not be guaranteed. This office is not party to any patient's health insurance plan contract and therefore will not be able to request an insurance plan to pay for a patient's services.

_____ Fees are charged for letters of medical necessity (labs, prescription drugs and nutritional supplements), disability assessment, preauthorization process for medications and procedures, etc.

The current office charges are as follows:

_____ New patient initial visits average about $380 (can be between $280 and $650 excluding labs, prescription drugs, nutritional supplements, and any other procedures).
Follow up visits average between $200 to $400 excluding labs, prescription drugs, nutritional supplements, and any other procedures.

_____ Office charges will be adjusted without warning at the discretion of the practice.

Please sign & initial confirming your understanding and agreement to the office policies & procedures : _____ **Today's Date:** _____

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