Agreement to Pay for Non-Covered Services as of 02/05/13

Authorization:
I [name] _____ authorize medical treatment of myself by the physicians, nurses, medical assistants and other clinical staff at Greenwich Pure Medical, LLC (GPM).

Notice as to Nature of Services:
I understand that care I receive at GPM may be non-traditional or non-conventional. Such services are commonly referred to as integrative, functional, complementary or alternative or holistic medicine. Many of these services may not be recognized as standard medical practices, and may be considered to be unproven or supported by inadequate evidence by medical associations or agencies. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me.

I understand my doctor may request laboratory evaluation that may include venipuncture, and analysis of stool, urine and saliva, and that some of these tests, while approved for patient use, may not be considered standard testing or subjected to interpretations based upon functional approaches to medicines.

Notice That Services are Additional to Primary Care:
I understand that the GPM practitioners' practice is focused on a complete holistic approach to care and it is in my best interest to ensure that I am fully informed about all available conventional means to address any medical conditions I may have. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems.

I also understand that it is my responsibility to inform GPM who my previous physician and current specialists are, to let them know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physician and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let specialists know about any treatments performed at GPM in order to properly and safely coordinate my care.

Financial/Insurance Responsibility for All Services:
I understand and agree to the following policies regarding financial and insurance responsibilities:

1. Payment is required at each visit.
2. I am responsible for charges incurred for all treatment rendered including co-payments, deductible amounts, non-covered and excluded items.
3. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary.

4. I understand that my insurance carrier or other third-party payers responsible for coverage of my medical expenses may deny coverage because of differences between integrative and conventional medicine, but I choose to receive and will pay for such care.
5. I understand that I am responsible for payment of fees for laboratory or other clinical services ordered by my treatment practitioner(s).
6. GPM will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.

I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for GPM to take action to secure payment of an outstanding balance owed.

Claim Management:
My treating practitioner(s) may respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information.

GPM will make an effort to provide sufficient information to allow an insurer to determine what services it will reimburse, but is not responsible for any insurance company decision. Given the uncertainty that pervades insurance decisions, GPM cannot be responsible for any information that turns out to be incorrect.

No Guarantees:
I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at GPM.

Revocation of Authorizations:
The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

Patient Acknowledgment:
By my signature below, I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party. I agree that I will make no audio/video recordings within GPM's offices.

Signature: _____ **Date:** _____