Payment for Non-Covered Services Agreement
As of 01/01/14

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 some of the care and services I receive at **GPM** may be considered Non-Conventional by many traditional Medical Organizations Standards. Such services are commonly referred to as Functional, Integrative, Complementary, Alternative or Holistic. Some of these services may not be recognized as Standard Medical Practices, and may be considered to be unproven or unsupported by adequate evidence by many Medical Associations or Governmental Agencies.

I understand that in the delivery of said care and the provision of said services, **GPM** may conduct evaluations of my blood, stool, urine, hair, saliva, sweat and other bodily fluids. Some of these tests, while approved for patient use, may not be considered Standard Medical Testing and are subjected to interpretations based upon Functional Medicine approaches to health. In these instances, my commercial insurance carrier may refuse to reimburse **GPM** or the analyzing Laboratory for such services. Technology based delivery of care by means of Online Email Communication via the Internet (*CPT 99444*), Telephone Evaluation and Management Communication (*CPT 99441-99443*), Text Messaging and/or the use of Web Cameras may not be eligible for coverage and/or reimbursement.

Notice That Services are Additional to Primary Care:
I understand that the **GPM's** practice is focused on a Comprehensive Approach to care and it is in my best interest to ensure that I am fully informed about all available conventional as well as complementary means to address any medical conditions I may have. I understand that in addition to having Dr. Gamble as my Primary Care Physician, it may be in my best interest to have appropriate specialists, such as a cardiologist, if I have heart problems. **I also understand** that it is my responsibility to inform **GPM** of who my previous physicians and current specialists are, let **GPM** know of any diagnoses I have received, and reveal any treatments I have had or am now undergoing for current conditions. I understand that I should keep both Dr. Gamble and any other 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 Responsibility:
I understand and agree to the following:

1. Payment is required at each visit.
2. **I am responsible for charges incurred for ALL treatments rendered including but not limited to:** Co-Payments, Co-Insurance, Deductibles, Preventative Counseling, Nutritional Counseling, Interventional Procedures, Specimen Collection, Vitamins, Supplements, Diagnostic Procedures, Injections, Infusions, Medications, Therapeutic Procedures, Online E/M

Communications, Telephone E/M Communications, Health & Behavioral Interventions, Extensive Administrative Paperwork Completion as well as Other Non-Covered and Excluded Items.

3. I agree that I am responsible for ALL payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary.
4. I understand my commercial insurance carrier may deny coverage because of perceived differences in Integrative and Functional 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 services ordered by **GPM**.

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 against me to secure payment of an outstanding balance owed.

Claim Management:

GPM will respond to my commercial insurance carriers' requests for information, but will not be obligated to take action on my behalf against them for collecting or negotiating my insurance claim. **GPM** will provide sufficient information to allow my commercial insurance carrier to determine what services it will reimburse, but **GPM** is not responsible for my commercial insurance carriers' decision. I have been encouraged to review my commercial insurance carriers' guidelines to determine if coverage is available for these services.

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 Functional Medicine Diagnosis or Integrative Medical Treatment 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 commercial insurance carrier is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

Patient Name: _____

Signature: _____ **Date:** _____

Witness Name: _____

Signature: _____ **Date:** _____