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FINANCIAL POLICY AGREEMENT

PHYSICIAN CONSULTATION

INITIAL CONSULTATION includes a review of current medical issues, past records, and a review of diagnostic and treatment options. The hourly rate is $500.00, and is billed $125 per 15-minutes. A summary report will be provided at the end of the consultation.

For an appointment, please submit the Registration Packet that includes the following:

1. Patient Registration Form
2. Scheduling Fee $125.00 – **non-refundable**; applied towards Total Consultation Fee
3. Financial Policy Agreement
4. Disclaimer & Informed Consent
5. Privacy Notice
6. ABTC 26-page Questionnaire (including immunization record) – for Child ONLY
7. Medical Questionnaire – for Adult ONLY
8. Exposure History Form – for Adult ONLY

IMPORTANT: This Packet is due at least **seven (7) business days** before your appointment. LATE SUBMISSION will result in APPOINTMENT CANCELLATION AND FORFEITURE OF SCHEDULING FEE**.** A NEW Scheduling Fee will be required if rebooking. This is strictly-enforced.

FOLLOW-UP CONSULTATION includes a review of interval history and laboratory data. The hourly rate is $500 and is billed $125 per 15-minutes. A **non-refundable** Scheduling Fee of $125.00 is required. A summary report will be provided at the end of the consultation.

- An updated Rating Scale and List of Supplements must be submitted at least three (3) days before your appointment. This will help reduce the expense for the patient.

CANCELLATION AND RESCHEDULING FEE POLICY

- All appointments must be cancelled at least **three (3) business days** before a scheduled appointment. The Scheduling Fee will be forfeited if cancelled or rescheduled less than 3 business days to a scheduled appointment, and a new Scheduling Fee will be required when rebooking.
- When rescheduling, the new booking must be scheduled to **within a month** from the original appointment date.
- Special consideration is given to true medical emergencies. A physician's note is required for documentation and consideration.

MISSED / NO SHOW APPOINTMENT POLICY

The hourly rate of $500 will be charged if a patient misses an appointment.

INTRAVENOUS (IV) THERAPY

PHYSICIAN CONSULTATION
A consultation is required prior to the therapy. The Physician Consultation fees and policies are as noted above.

INTRAVENOUS INFUSION TREATMENT

- Due to prescription requirements and high costs for IV nutrients, FULL payment is due at the time of scheduling. The IV Therapy Fee is FINAL, NON-REFUNDABLE, NON-EXCHANGEABLE, & NON-TRANSFERABLE**.**
- You agree to allow our office to charge your credit card for the cost of the service you are scheduled to receive. You accept full responsibility to ensure that you pay any fees due at the time your appointment is scheduled.
- **Cancellation and Rescheduling Policy**
  - If you cancel/reschedule **less than 24 hours** to the appointment **AND/OR** you cancel and do not reschedule, **you forfeit the cost of the service scheduled on that day** as we cannot use this supplement/medication for another patient. NO EXCEPTIONS TO THIS POLICY**.**
  - When rescheduling, the new appointment date must be **within a month** from original appointment date.
- **Missed/No Show Appointment Policy**
  The cost for the service is forfeited if you miss the appointment.

XLR8 COLD LASER THERAPY

PHYSICIAN CONSULTATION
A consultation is required prior to therapy. The Physician Consultation fees and policies are as noted above.

XLR8 COLD LASER THERAPY SESSIONS

- Treatment Fee is $10.00 per minute. Payment is due at the time of the session.
- Fee Schedule is determined by the Total Contact Time with the doctor or the medical staff.
  (Total Contact Time = Doctor/Staff time + Cold Laser Therapy time)
  Therapy by Doctor = $125 per 15 min. of Total Contact Time + $10/min. of therapy time
  Therapy by Staff = $15.00 per 15 min. of Total Contact Time + $10/min. of therapy time
- **Cancellation and Rescheduling Policy**
  We require at least 24 hours-advance notice for cancellation and rescheduling.

HYPERBARIC OXYGEN THERAPY (HBOT)

PHYSICIAN CONSULTATION

A consultation is required prior to therapy. The Physician Consultation fees and policies are as noted above.

HBOT SESSIONS

- The Fee Schedule for HBOT:
  Single Session = $110.00 per session
  Package Plan = $500.00 per five (5) sessions
  Fees are due at the time of scheduling. Each session is a maximum of 1 hour.
  All purchased sessions are NON-REFUNDABLE, NON-TRANSFERABLE, NON-EXCHANGEABLE.
  The paid service is **valid for 6 months** from original date of payment.

- **Cancellation and Rescheduling Policy**
  - We require at least 24 hours advance notice.
  - If you cancel/reschedule **LESS than 24 hours** before the appointment **AND/OR** you cancel and do not reschedule, you forfeit the cost for that day's session.
  - When rescheduling, the new appointment must be **within a month** from original appointment date or the paid service will be forfeited.
  - Special consideration given to true medical emergencies or a natural disaster. A physician's note is required for documentation and consideration.

- **Missed/No Show Appointment Policy**: The session fee will be forfeited and considered a completed session if the patient misses a scheduled session.

OFFICE POLICIES FOR ALL CONSULTATIONS & THERAPY SESSIONS

We do not participate with any insurance company. We do not give procedure or diagnostic codes, no exceptions. You are responsible for payment in full. FULL payment is due at the time of service. We accept cash (in U.S. currency) and Visa/MasterCard only.

"Buy Now Pay Later" option thru PayPal is offered as a form of payment. It allows the ability to spread payments over time, making purchases affordable. This is subject to consumer credit approval thru PayPal. There is a 3% processing fee when using PayPal.

All Consultation and Therapy fees are non-refundable, non-transferable, and non-exchangeable. All consultation and therapy sessions are valid only for 6 Months from the original date of payment.

Appointment cancellation/rescheduling may be done by phone. If you reach our voicemail, please leave your name, date of birth, and telephone number. You will be contacted to confirm the message. IF YOU DO NOT GET A CALL-BACK, IT MEANS WE DID NOT GET YOUR MESSAGE.

The only exceptions to the Cancellation/Rescheduling and the Missed Appointment policies are true medical emergencies, or a natural disaster. A physician's note is required for documentation and consideration.

Prescription refills are initiated by contacting the pharmacy. Per strict FDA regulations, a consultation with the doctor at least once per calendar year is required to be considered an active patient.

There is a charge for copies of medical records. A Medical Release Form must be completed. Completion of health-related forms and narrative reports for lawyers, for insurance purposes, etc. will be billed at our standard hourly rate. Please contact our office for updated rates.

Phone and online consultations are welcomed. This is convenient for long-distance travelers. It is billed at our standard hourly rate, divided into 15-minute increments.

Email communication is viewed as billable time. It is billed based on our standard hourly rate. Personal email use is the patient's responsibility. A patient who emails protected health and personal information via email assumes responsibility for using their email.

Delinquent Accounts: All balances not paid following the rendered service will be considered delinquent and will be subject to a 3% monthly late charge until fully settled, with the member's account reported to the collection agencies after 2 months of non-payment. Any collection or attorney's fees incurred because of a delinquent account will be the responsibility of the patient.

FINANCIAL POLICY AGREEMENT

I, (Patient Name) _____ (Date of Birth) _____ have read, fully understood, and agree with the billing rates and the office policies, including the Registration Packet Submission policy, Cancellation/Rescheduling and Missed Appointment policies, noted in this agreement.

PLEASE INITIAL THE FOLLOWING AND SIGN BELOW:

___ I am financially responsible for the billing charges incurred and/or services rendered, and authorize Advance Biomedical Treatment Center to charge my credit card account.

___ I am aware that all the fees noted above are **NON-REFUNDABLE,** and that the paid services are **NON-TRANSFERABLE, NON-EXCHANGEABLE**.

___ I agree to abide by this Financial Policy Agreement and the mandates stated above.

_____ _____
Signature of Patient Date

If patient is a minor, a parent /guardian must sign below:

_____ _____
Printed Name and Signature of Parent/Guardian Date

Preferred Method of Payment:

___ Cash (U.S. Currency)

___ Visa / MasterCard: Name on Card: _____

Card no. _____ Exp Date _____ CVV _____ Zip Code_____

___ "Buy Now Pay Later" option thru PayPal. It allows the ability to spread payments over time, making purchases affordable. This is subject to consumer credit approval thru PayPal. A 3% processing fee will be applied.