29995 Technology Drive Suite 201
Murrieta, Ca 92563
Telephone: (951) 461-3021
Fax: (951) 461-8898

Service and Financial Agreement

To help us provide the most efficient and reasonable health care services, it is necessary for **An Optimal You** to have a Service and Financial Agreement stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our office policy to collect a dollar amount at the time of service.

The scope and manner of services being performed by providers at An Optimal You are including but not limited to:

1. Consultation and treatment on Bio-Identical hormones therapy including implants of Bio-Identical hormone pellets.
2. Consultation and treatment on Anti-Aging.
3. Consultation and administration of IV therapies.
4. Consultation and treatment on Prolozone therapy.
5. Consultation and treatment on Ozone therapy.
6. Bio-Energy Testing

Bio-Identical hormone balancing and/or replacement as well as anti-aging and IV treatments are a unique practice and is generally considered a form of alternative medicine. Even though our providers are licensed, insurances do not typically recognize these procedures as medically necessary medicine and they consider it similar to plastic surgery (esthetic medicine). These services are not covered by health insurance plans.

An Optimal You is not associated with any insurance companies, which means insurances are not obligated to pay for services rendered. An Optimal You will not submit a health insurance claim to a patient's health insurance including Medicare. The patient agrees not to submit a health insurance claim to his/her insurance company including Medicare for the services, even if such services are otherwise covered by his/her insurance or Medicare. An Optimal You will not communicate in any way with insurance companies. We will not call, write, pre-certify, or make any contact with the patient's insurance company. We will also not respond to any letters or calls from any insurance company for services provided by our office.

In order to assist us in helping you, you agree to:

1. Provide us with current and updated information on yourself and to keep all changes up to date.
2. Pay for your service at the time of services being rendered.
3. All payment arrangements are up to An Optimal You sole discretion and must be recurring with a valid credit card on file. All patients must have a recurring payment plan agreement on file before arranging payments. It is your responsibility to keep your credit card up to date. Failure to do so will incur an interest fee and may jeopardize your eligibility to participate in this service as well as possible dismissal from the practice if no communication is made within 10 days of being notified of a charge denial (30 days of credit card issue).
4. All IV therapy packages must have an IV Therapy Service Agreement on file before purchasing.
5. An Optimal You may choose, at An Optimal You sole discretion, to provide a refund to Patient or to charge Patient a reduced rate under special circumstance for services rendered otherwise all services are non-refundable.
6. If paying with check, ensure that your bank does not return your check to us. All returned checks will be subject to a $25 NSF check fee and may jeopardize your ability to pay with a check in the future.
7. Discuss your balance due with the office staff. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the rest of the office staff on any dollar amount questions or problems you may have. If they cannot help you or answer your questions to your satisfaction, then please, do not hesitate to contact the office executive manager.

8. All outstanding balances are due within 30 days of acquiring it or at your next office visit whichever comes first.
9. All outstanding balances that are not paid by the due date will incur an interest fee and must be paid within 30 days from due date otherwise possible dismissal from the practice may occur. The interest rate is at An Optimal You sole discretion.

Payment for services rendered and any outstanding balance (excluding payment plans) are due in full at the time of service. Payment may be made by cash, check, visa, or MasterCard. As the undersigned, you agree, whether signing as a patient or guarantor, to guarantee payment of the account in accordance to policies and terms of An Optimal You.

Release of Information

I hereby authorize An Optimal You to release all medical information (including, but not limited to information relating to mental evaluation and treatment, sickle cell anemia, alcohol and drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnosis, if any such information exists) to all my agents, or the Social Security Administration, as may be required or requested for the processing of social security or disability claims.

Notice of Privacy Practice

I acknowledge receipt of the Notice of Privacy Practices (HIPAA). I have had the opportunity to review and consider the contents of the Notice of Privacy Practices. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information (PHI) and electronic PHI to carry out treatment, payment activities and healthcare operation, and I have access to a copy of this office's Notice of Privacy Practices.

Office Policies

In order for An Optimal You to provide proper treatment, patients must be responsible for setting up follow up visits to continue their treatment plan. Follow up visits on hormone replacement therapy, anti-aging services, or other medically supervised treatment plans are required on a regular basis as advised by the treating provider based on your medical needs.

It is the patient's responsibility to know what type of appointment he/she is due for. If unsure of what type of appointment is needed is it best to leave a detailed message of your symptoms for the provider that is treating you to get a recommendation of what type of appointment you may need. Failure to schedule the appropriate appointment type will result in a follow up consultation fee (i.e. scheduling a re-pellet procedure but seeing the provider for an office visit instead will incur an office visit charge—it is not a free visit).

Blood work is advised to be done prior to most follow up appointments. Failure to get bloodwork done does not justify the cancellation of your appointment with less than 2 business day's notice.

Insertion of hormone pellets are every 3 to 6 months. An Optimal You will usually combine your follow up visit with your re-pellet procedure. Pellet boosts are done at no charge 4 to 5 weeks after insertion of pellets if the patient is still symptomatic (5 weeks or longer past the pellet insertion will incur a charge). It is your responsibility to communicate to our office in a timely manner if your symptoms persist at 4 weeks.

Follow up visits for patients on creams, capsules, or injections are typically every 3 to 6 months depending on your medical condition. Any Bio-Identical hormone prescriptions (excluding pellets) will be sent directly to the compounding pharmacy and these are paid by you directly to the pharmacy. For prescription refills, we ask that you contact the pharmacy directly a week in advance since compounded medications take time. Contact our office if you run into any difficulties.

Single IV therapy treatments are the responsibility of the patient at the time of service. Patients are responsible for the full price of the IV therapy treatment whether the treatment is fully or successfully administered. Single IV therapy treatments that are offered in IV packages will not count towards the IV package series if the IV package is not purchased within the same day of receiving the single IV therapy treatment. IVs that are offered within IV combo packages cannot be used as individual single IVs. All IVs that are included in the IV combo packages must be administer on the same day (no splitting of the IVs as single IVs to be administer on separate days). IV packages offered by An Optimal You must be used within 60 to 90 days (depends on the IV package) from the purchased date. Failure to use them within this time frame will forfeit any remaining IV for future use or credit.

An Optimal You has a rescheduling/cancellation policy for all initial and follow up appointments.
Rescheduling/cancelling appointments with short notice and/or missing appointments adversely affects our ability to accommodate and help other patients. We do our best to accommodate every patient's needs and we ask that you respect other patients by giving our office adequate notice when needing to reschedule/cancel an appointment. We ask for your help in reducing short notice rescheduling/cancellation and/or missed appointments by adhering to the following:

1. We require more than **2 business days' notice** (a business day is Monday-Friday during office hours, non-holidays. Office hours are Monday, Tuesday and Thursday 9 am to 5 pm. Wednesday and Friday 9 am to 1pm) to reschedule or cancel your appointment. Failure to give us **2 business days' notice** prior to your appointment will result in incurring fees (of course, we do understand significant emergencies and encourage you to contact our office immediately if an unforeseen event occurs and we will evaluate your situation on an individual basis). Fees will be due at your next office visit. If you have rescheduled/cancelled with adequate notice (2 business days' or more) you will not incur any fees. Repeated short notice cancellations may result in discharge from the practice.
2. For optimal treatment, communication is necessary, therefore any initial consultations that are missed (i.e. no contact with our office) will not be re-scheduled. If an established patient misses 2 appointments (i.e. no communication to our office regarding the need to reschedule/cancel the appointment), that patient will be discharged from our practice.

As the undersign you agree, whether signing as a patient or guarantor, that you have reviewed and understood the policies set by An Optimal You regarding the rescheduling/cancellation notice and associated fees, prescription refills, payment policies, financial policy and any other policy set forth by An Optimal You.

As the undersign you also agree, whether signing as a patient or guarantor, that you have agreed to examine these policies prior to receiving any services by An Optimal You. These policies along with pricing for services render may be modified by An Optimal You's sole discretion without notice to patients. Patient agrees to be bound by any modifications upon successively obtaining any service from An Optimal You. Patient agrees and understands that if Patient does not agree to the modifications, then Patient shall seek services elsewhere.

This is a contract entered into by An Optimal You (hereinafter referred to as "the Provider") and _____ (hereinafter referred to as "the Patient") on this date: _____

The Provider's place of business is 29995 Technology Drive Ste 201 Murrieta, Ca 92563 and the Patient's place of residence: _____
Address City State Zip Code

This contract shall be governed by the laws of the County of Riverside in the State of California and any applicable Federal law.

The undersigned certifies that he/she has read, or has been read, the foregoing, that he/she understands the foregoing, that he/she has received a copy/or has access to a copy thereof, that he/she has been given the opportunity to ask any questions that he/she may have concerning the foregoing, and that he/she is the patient or duly authorized representative of the patient. The undersigned, having read and understood the agreements, accepts the Service and Financial Agreement, the Release of Information Agreement, Notice of Privacy Practice, Rescheduling/Cancellation and/or missed appointment and An Optimal You Office Policies.

_____ _____
Please Print Patient's Name Date

_____ _____
Patient's Signature or Guardian Date

_____ _____
Responsible Person (Guarantor) Signature Date

_____ _____
Staff Signature Date