**PflegMed, LLC: Authorizations and Acknowledgements**

Treatment Authorization: I authorize medical and health care treatment of \_\_\_\_ myself by Jennifer Pfleghaar, D.O.

Medical Records Release and Authorization: I authorize PflegMed, LLC to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. I also authorize any physician or health care provider I have seen, to release my medical records to Dr. Pfleghaar.

Notice as to Possible Non-Coverage of Service: I understand that because of the non-conventional nature of Dr. Pfleghaar’s services, insurance reimbursement may not be available. My insurance company may not pay for the acupuncture services, for example, and in some cases, may not pay for office visits where the focus of the consultation is on wellness, herbal medicine, or other CAM services. Some of the lab tests that are ordered particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics may also not be reimbursed.

Financial/Insurance Responsibility: I understand that PflegMed, LLC does not participate in insurance plans. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or mot medically necessary. I also agree to be responsible for cost and expenses, including court costs, attorney fees and interest, should be necessary for PflegMed, LLC to take action to secure payment of any outstanding balance owed.

Claim Management: I understand that it is my responsibility to know my plan benefits. PflegMed, LLC may offer some assistance, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect. PflegMed, LLC will 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 for requests for information.

Cancellation Fee: A cancellation fee of $50 will be assessed for missed appointments not canceled with more than 48 hours (2 business days) notice.

Misc Fees: Paperwork, ex: disability, workman’s comp, exemptions, ect, will have a fee of $25

For requests of copies of the medical in accordance with section [3701.742](https://codes.ohio.gov/ohio-revised-code/section-3701.742) of the Ohio Revised Code: Twenty-five cents per page for the first ten pages, twenty cents per page for pages eleven through fifty, ten cents per page for pages fifty-one and higher.

Duration/Revocation of Authorization: The authorization may be revoked by me in writing at any time. Such revocations will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

For telemedicine urgent care visits: This service is not covered by insurance and will be offered at a rate of $150 per visit and evaluation. This urgent care evaluation and visit will last 15 minutes.

I received or was offered the privacy practices paperwork (available online):

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Date Patient/Guardian Signature Patient/Guardian Name Printed

Notice that Services are not Primary Care:

I understand that Dr. Pfleghaar is not acting as my primary care physician. I understand that even though she may address issues affecting my general health, the practice is focused on an integrative approach to medicine. It is in my best interest to also have a primary care physician to ensure that I am fully informed about all available conventional means to address any medical conditions I may have.

I also understand that it is my responsibility on an ongoing basis to inform Dr. Pfleghaar of the name and contact information for my primary care physician and treating specialist, of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions. I also understand that it is important for me to let my primary care physician know about any recommendations/treatments performed by Dr. Pfleghaar, in order to ensure that my care is properly coordinated.

My primary care physician is: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_