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Authorizations and Acknowledgements

Please initialize each area and sign the second page.

Patient's Name: _____

Date of Birth: _____

Treatment Authorization:

___ I authorize medical and health care treatment by Daphne Miller, MD, Avril Swan, MD, and Alex Zaphiris, MD.

Scheduling and Cancellations:

___ You may schedule an appointment by calling reception at 415-642-0333, or by emailing reception (reception@wholefamilymd.org). In general, appointments start on time. Should you need to cancel or change an appointment, we request that you notify us at least **2 full business days** before your scheduled appointment. Since we reserve your time slot specifically for you, late cancellations will incur a fee equal to the actual cost of your scheduled appointment.

After- Hours Coverage:

___ The doctors in this practice share after-hours call for our practice. We check telephone messages on a regular basis and return calls between 8PM and 9PM on weekdays and weekends. If you feel that the matter is too urgent to wait for us to call you back, you may page us following the prompts on our telephone answering system. Of course, if you are experiencing a medical emergency, please call 911 or go directly to an emergency room.

Telephone Consultations:

___ We are available for telephone consultations both during and after office hours. In general, for uncomplicated questions, there is no fee. However, if we feel that the consultation is complex, lengthy or replaces a face-to-face visit, there is a charge.

Medication refills:

___ We request that you allow five business days to process all routine medication refills. To request a refill simply contact your pharmacy and they will forward the request to our office.

Medical Records Release Authorization:

___ I authorize Drs. Miller, Swan, and Zaphiris to release my medical information to any physician or health care 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 Drs. Miller and Swan. This also extends to records regarding my child, if applicable.

Privacy Statement:

___ While Drs. Miller, Swan, and Zaphiris respect your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing their own internal operations, or as specifically authorized by you.

Test result reporting

___ Drs. Miller, Swan, and Zaphiris notify their patients about the results of **all** tests that are ordered, regardless of whether the findings are normal or abnormal. If you have undergone medical testing (including labs, X-rays, CAT scans, etc) and have not received the results within 14 business days, please notify our office either by telephone or by emailing reception (reception@wholefamilymd.org). While we make every effort to ensure that the results of all the tests that we order are reported back to our office, there are times when the labs or hospitals fail to send us these reports. Therefore we ask that you, as the patient, take the ultimate responsibility in ensuring that the results of all completed tests are reported back to you.

Financial/Insurance Responsibility:

___ I understand that Drs. Miller, Swan, and Zaphiris do not participate in insurance plans. I understand and agree that the doctors do not accept assignment, which means that payment will be required at each visit. I understand that I will receive a superbill or claim showing the cost and nature of the services and it will be my responsibility to submit the claim to my insurer. I understand that I am responsible for all charges incurred for treatments rendered, even if my insurance company determines that that any services are non-covered or excluded.

Notice as to Possible Non-Coverage of Services:

___ I understand that insurance reimbursement may not be available. My insurance company may not pay for office visits where the focus of the consultation is on wellness, herbal medicine, etc. 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.

Claim Management:

___ I understand that it is my responsibility to know my plan benefits. Our office may offer some assistance, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect. Our office 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.

Medicare Patients:

___ I am responsible for paying for the services I receive at the time of my visit We will then submit your superbill or claim to Medicare with the expectation that they will reimburse me directly. (Note: In most instances, Medicare and your secondary insurer will reimburse you a total of 82.5% of the amount you paid for your 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 diagnoses or treatments I receive.

Durations/Revocation of Authorizations:

___ I may revoke these authorizations in writing at any time. Such revocation 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.

I have read and I understand the **Authorizations and Acknowledgments** sheet, and I am prepared to establish care in this practice.

Patient Signature
(or Guardian's Signature, if patient is a minor)

Date