422 Montague Avenue
Suite 5
Greenwood, SC 29649

NEW PATIENT REGISTRATION FORM

NAME (last, first) _____ **DATE OF BIRTH**__/____/_____

LEGAL SEX ☐ Male ☐ Female

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE_____ **MOBILE PHONE** _____

E-MAIL ADDRESS _____ **Do you consent to receive texts at this mobile number?** ☐ Yes ☐ No

RACE ☐ African American/Black ☐ White ☐ Hispanic ☐ Asian ☐ Middle Eastern ☐ Prefer not to answer

PREFERRED LANGUAGE ☐ English ☐ Spanish ☐ Other ☐ Prefer not to answer

MARITAL STATUS ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Domestic Partner ☐ Single

PREFERRED PROVIDER ☐ Leslie Myers ☐ Theresa Lawson

EMERGENCY CONTACT _____ **PHONE** _____

RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION ☐ I will not be using insurance for my visits.

Primary Insurance Carrier	Secondary Insurance Carrier
Insurance Provider _____	Insurance Provider _____
Primary Name on Insurance Card _____	Primary Name on Insurance Card _____
Insurance ID # _____	Insurance ID # _____
Insured Person DOB _____	Insured Person DOB _____
Relationship to Patient _____	Relationship to Patient _____

NEW PATIENT MEDICAL INFORMATION

____/____/_____
Today's Date

Patient Demographics

Name DOB

Pharmacy Name Pharmacy Phone Pharmacy Street / City / State

Primary Care Provider

❑ **CHECK HERE IF YOU PLAN FOR BEST LIFE WELLNESS TO SERVE AS PRIMARY CARE PROVIDER**

Do you have an Advance Directive? ❑ **Yes** ❑ **No**

Medications *List all medications, both prescriptions and over-the-counter, that you are presently taking.*

Medication	Dose/ Strength	How often do you take this medication?	Reason for taking this medication?	Who prescribed this medication for you?

Allergies *List all allergies and the reaction that occurred.*

Allergic to?	Describe reaction that occurred:

Medical/Surgical History *List all medical conditions and previous surgeries.*

	YES
Adenoidectomy	❑
Appendectomy	❑
Breast Implants	❑
Cataract Removal	❑
Cesarean Section	❑
Cholecystectomy (Gallbladder Removal)	❑
Ear Tubes	❑

	YES
Hysterectomy (Ovaries/Tubes Removed)	❑
Hysterectomy (Ovaries/Tubes NOT Removed)	❑
Tonsillectomy	❑
No Surgical History	❑
Other:	

Family Medical History *Mark the box beside any family medical history.*

	Father	Mother	Grandparent	Sister/Brother
Cancer	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑

	Father	Mother	Grandparent	Sister/Brother
Heart Disease	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑

	Father	Mother	Grandparent	Sister/Brother
Stroke	❑	❑	❑	❑
Other	❑	❑	❑	❑

NEW PATIENT MEDICAL INFORMATION

____/____/_____
Today's Date

Name _____ **DOB** _____

Social History

	YES	NO	Type	Amount	Years Quit?
Do you currently or have you in the past used tobacco products?	❑	❑			
Do you currently or have you in the past used e-cigarette/vape devices?	❑	❑			
Do you currently use any illicit or recreational drugs?	❑	❑			

Please indicate your level of alcohol consumption: ❑None ❑Occasional ❑Moderate ❑Heavy

Review of Symptoms *Indicate if you have experienced any of these symptoms in the **previous six months**.*

	YES	NO
Abuse or Domestic Violence	❑	❑
Allergies/Hay Fever	❑	❑
Anemia	❑	❑
Anesthesia Complications	❑	❑
Asthma	❑	❑
Birth Defects or Inherited Disease	❑	❑
Bladder or Kidney Problems	❑	❑
Blood Diseases	❑	❑
COPD	❑	❑
Cancer	❑	❑
Congestive Heart Failure (CHF)	❑	❑
Coronary Artery Disease	❑	❑
Developmental or Behavioral Disorders	❑	❑
Diabetes	❑	❑
Ear or Hearing Problems	❑	❑
Eye or Vision Problems	❑	❑
Fibromyalgia	❑	❑
GI Problems	❑	❑
Gout	❑	❑
Headaches	❑	❑

	YES	NO
Heart Disease	❑	❑
High Cholesterol	❑	❑
Hospitalizations	❑	❑
Hypertension	❑	❑
Immunocompromised	❑	❑
Liver Disease	❑	❑
Lung Disease	❑	❑
Mental Illness (Depression, Anxiety, Other)	❑	❑
Muscle, Joint, or Bone Problems	❑	❑
Neurological Disorder	❑	❑
Obesity	❑	❑
Osteoporosis	❑	❑
Reflux/GERD	❑	❑
Seizures/Epilepsy	❑	❑
Skin Problems	❑	❑
Stroke	❑	❑
Thrombophilia/Blood Clots	❑	❑
Thyroid Problems	❑	❑

OTHER: *(Please list)*

NOTES:

Females Only *Please complete and check all that apply.*

Pregnant? ☐ **Yes** ☐ **No** **Birth Control Method:** _____

Number of: Pregnancies _____ Abortions _____ Miscarriages _____ Live Births _____

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CONSENT FOR TREATMENT

General Consent

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that:

1) You consent to any and all health care treatment and diagnostic procedures provided by Best Life Wellness, LLC its associated clinicians and other personnel.

2) You consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment, and health care operations consistent with the Best Life Wellness, LLC Notice of Privacy Practices.

3) You give permission to obtain all of your medication/prescription history when using an electronic system to process prescriptions for your medical treatment.

4) You have provided, to the best of your ability, information that is accurate regarding medical and surgical history, current and previous medications and/or treatments, current or past substance use, and current patient- provider relationships.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. You have the right at any time to refuse any procedure or treatment and/or to discontinue services. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

Telehealth Consent

I hereby authorize Best Life Wellness, LLC to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition. I understand that while Telehealth has been found to be effective in treating a wide range of conditions, there is no guarantee that Telehealth is safe or effective for all individuals or situations. Providers are not able to perform a true physical exam, check vital signs, or take other actions that are part of the standard of care for the prescription of certain medications or the management of certain conditions. If my provider makes recommendations for me to take actions to mitigate risks of adverse outcomes, it is my responsibility to do so, and I acknowledge that not doing so may result in harm or an adverse outcome.

I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended. I accept that the professionals can conduct interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

I understand that Best Life Wellness LLC uses telehealth technology that is designed to protect my privacy but acknowledge that electronic medical communications carry some level of risk for accidental disclosures such as hacking or interceptions. I understand that there is a risk of being heard by people near me and that I am responsible for using a location that is private and free from distractions or intrusions. I agree that my medical records on telehealth can be kept for further evaluation, analysis, and documentation, and in all of these, my information will be kept private.

I understand that my current insurance may not cover the cost of visits conducted via telehealth or additional fees of the telehealth practices, and I acknowledge that I will be responsible for any fee that my insurance company does not cover.

_____ _____

Patient Signature Date

_____

Relationship to Patient

422 Montague Avenue
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HIPAA FORM FOR DISCLOSURE PREFERENCES AND AUTHORIZATIONS

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, plans for future care, and payment for the services provided. We use this information to:

- Plan your care or treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided
- To submit the necessary information to your insurance company or other agencies/individuals for coverage verification, provision of diagnosis and treatment information, and payment of services provided

Only as permitted or required by federal or state law, may we use your protected healthcare information to do the following:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment, and/or healthcare
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment

Please use the form below to indicate the ways in which we may contact you with different types of information.

Information	Email	Voicemail (home)	Voicemail (mobile)	Secure Test Message
Appointments	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Test Results	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Referrals	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Financial Information	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please indicate any individuals to whom we are authorized to release information and the type of information authorized for release.

Name	Relationship	Preferred Contact Number	Appointment	Medical	Financial
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Patient Name _____ DOB _____

You have the right to read and request a copy of our “Notice of Privacy Practices” prior to signing this authorization. The "Notice of Privacy Practices" document provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Signature _____ Date _____

XXX-XX-_____ ❑ CHECK HERE IF YOU WOULD LIKE TO DECLINE THIS INFORMATION

Last 4 digits of SS# *Please speak to our staff to discuss providing an alternate ID number.

Relationship to Patient _____ Printed Name (if other than patient) _____

The signature below is an attestation that you have received and reviewed our “Notice of Privacy Practices”.

Patient Signature _____ Date _____

Relationship to Patient _____ Printed Name (if other than patient) _____

Patient Name _____ DOB _____

422 Montague Avenue
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Greenwood, SC 29649

NOTICE OF PRIVACY POLICIES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

PATIENT HEALTH INFORMATION (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your PHI also includes payment, billing, and insurance information. We are committed to protecting the privacy of your PHI. This Notice of Privacy Practices (Notice) describes how we may use and disclose (share outside of our practice or network) your PHI to carry out treatment, payment, or health care operations for administrative purposes, for evaluation of the quality of care, etc. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

TREATMENT

We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, etc.

PAYMENT

We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

OPERATION

We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a healthcare office that you may learn information regarding other patients, or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI. We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other healthcare providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

SPECIAL SITUATIONS THAT DO NOT REQUIRE PATIENT PERMISSION

We may be required by law to report animal bites, gunshot wounds, suspected abuse, or neglect of vulnerable individuals, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

MILITARY ACTIVITY AND NATIONAL SECURITY

When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services. In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

INDIVIDUAL RIGHTS

You have certain rights with regard to your PHI, for example: Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment. You may ask us to communicate with you confidentially by, for example, sending notices to a special address. In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies. If you believe the information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12-month period is free. There will be charges for additional reports. You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you with a copy of this Notice prior to or at the time of initial treatment at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

OUR LEGAL DUTY

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the reception area and on our website at www.bestlifewellnesscares.com. You can also request a copy of our Notice at any time. If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

If you have any questions, requests, or complaints, please contact one or both of the following:

Best Life Wellness, LLC
Attn: Leslie Myers (Designated Privacy Officer)
422 Montague Avenue, Suite 5
Greenwood, SC 29649
Phone: (864) 990-5074
Email: lmyers@bestlifewellnesscares.com

US DHHS Attn: HIPAA
Atlanta Federal Center
Suite 3B70 61 Forsyth Street
Atlanta, GA 30303-8909

422 Montague Avenue
Suite 5
Greenwood, SC 29649

OFFICE POLICIES AND PATIENT GUIDE

APPOINTMENT NEEDS

Our team and providers are committed to providing you with high-quality care. While we will make every effort to accommodate your urgent needs, please understand that it may not always be possible due to the level of patient demand and the availability of healthcare providers. It is important to note that we do not offer emergency services. In the event of a situation requiring immediate attention, please dial 911 or visit the nearest emergency room. For urgent mental health concerns, please contact the SC Department of Mental Health's Mobile Crisis Team at 833-364-2274 or 911.

Patients have 3 ways to request appointments:

1. Phone (864) 990-5074 - This is the preferred way to request an **urgent** appointment or specific limitations as these appointments quickly fill up.
2. Klara texting
3. Patient portal through Athena - This method is the slowest due to the nature of the process, so if you have specific limitations for your availability, the other two methods are preferred.

APPOINTMENT REMINDERS

Appointment reminders are made to the best of our ability and as a courtesy. However, it is important to note that clients are ultimately responsible for managing their appointments and arriving on time. For more information regarding our policy on missed appointments, please refer to our Financial Policy and Disclosure.

PATIENT COMMUNICATION / SOCIAL MEDIA POLICY

As healthcare professionals, we want to ensure that each patient's confidential information is protected and that patients receive the healthcare they deserve. For this reason, staff and providers at Best Life Wellness, LLC are not able to communicate with patients regarding their care through personal accounts such as social media, private text, or personal email. We encourage patients to use the Klara app for texting, the Patient Portal for messaging, or telephone to the office to reach our healthcare team. This ensures clear and secure communication and enables us to provide you with the highest quality of care. Thank you for your continued trust in Best Life Wellness, LLC.

Our staff and providers work hard to provide the care that you deserve. Every communication is important to us - calls and messages are answered as promptly as possible. We appreciate your patience should you have to wait on hold or leave a voice mail message. Please be aware that our staff and providers will not leave their scheduled patients to return routine phone calls and messages; these are generally answered after patient care sessions are finished. Because our providers have appointments on nights and weekends, they are unable to respond to messages outside of normal business hours. If you need to consult with your provider, we encourage you to schedule a telehealth or office visit. It is important to us to have the time you deserve to have your needs met and our providers rarely have time during scheduled patient care to make phone calls.

PATIENT ASSISTANCE RESPONSE TIME GOALS

Our medical staff strives to provide timely responses to patient requests for assistance. However, please note that immediate response may not always be possible. Our expected response time goals:

- Return communication for a non-emergent medical question - within 2 business days
- Return communication for a billing question - within 2 business days
- Requests for prescription renewals - within 3 business days
- Requests to complete forms & write letters within 10 business days
- Requests for copies of medical charts - within 30 days

PRESCRIPTION REFILLS

Our goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

1. Please come to your appointment prepared to request necessary refills and discuss any questions or concerns regarding medications.
2. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to two (2) business days, so do not wait to call. If you use a mail order pharmacy, please contact us ten (10) days before your medication is due to run out.
3. Medication refills will only be addressed during regular staff business hours (Monday – Friday (8:00am – 5:00pm). No prescriptions will be refilled on weekends or holidays outside of scheduled appointments.

4. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow up appointment.
5. Due to the volume of automated refill requests received from pharmacies, we cannot refill medication without patient request. If your pharmacy has submitted an automated refill request, please contact the office so that we can process the request in a timely manner.
6. Some medications require prior authorization, and this can delay filling of your prescription. Please notify us if this is being required by your insurance. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
7. It is important to keep your scheduled appointment to ensure that you receive timely refills. If you miss your appointment and require refills prior to your next appointment, you will be charged a prescription fee of $10. Repeated no shows or cancellations will result in a denial of refills.
8. A prescription fee of $10 is applied to prescriptions requested outside of a visit.
9. Patients requesting new prescriptions, antibiotics, or medication refills not prescribed by our office must be seen for an appointment. Telehealth may be an option for urgent needs if appropriate.

IN-OFFICE MEDICATION PICK-UP POLICY

To pick up medication from our office, patients must provide written consent via the Klara messaging system to authorize another person to collect it. Furthermore, all medication pick-ups necessitate a current photo ID and the signature of the individual retrieving the medication. This applies to both the patient and an authorized person.

CONTROLLED SUBSTANCE PRESCRIBING

All previous prescriptions are recorded and will be retrieved from the South Carolina prescription monitoring program, known as SCRIPTS (South Carolina Reporting & Identification Prescription Tracking System) before any transferred prescriptions are refilled. If a question of misuse of controlled substances is indicated, the prescribing practitioner will not authorize any refills for the applicable prescription and a urine test may be requested, or an appointment will be required to explore alternative treatment. Continuation of controlled substance prescription treatment is at the discretion of the practitioner.

Urine tests:

For new patients for whom controlled substances are prescribed, a urine drug test may be requested at the discretion of the prescribing practitioner. To initiate and monitor adherence to certain drug treatments, urine tests may be requested by the practitioner at any time. Urine tests may be requested on a random basis, either same-day or scheduled, at the discretion of the practitioner, and patient compliance is expected.

PATIENT DISMISSAL POLICY

Although it is an infrequent occurrence, a patient may be "dismissed" from the office and given 30 days to locate another medical office for their continued care. Our staff will send a letter by certified mail to your last known address, notifying you that you are being dismissed. Once we receive a signed release form from you, we will forward a copy of your medical records to your new healthcare provider.

You may be dismissed for one or more of the following:

- Repeated no-shows or cancellations
- Non-compliance to recommended medical plan of care
- Abusive, rude, disparaging, or threatening language or behavior to providers or staff
- Dishonesty or theft
- Failure to follow office policies
- Failure to meet financial obligation for services provided

_____ _____

Patient Signature Date

_____ _____

Relationship to Patient Printed Name (if other than patient)

422 Montague Avenue
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FINANCIAL POLICY AND DISCLOSURE

Thank you for choosing Best Life Wellness, LLC as your healthcare provider. We are committed to providing you with the quality healthcare you deserve. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Patients are responsible for the payment of all services provided by Best Life Wellness, LLC and its associates.

To facilitate timely billing and payment, we ask that patients assist by:

1. Providing current and updated information on your contact information and insurance
2. Presenting updated photo identification and insurance cards when changes are made
3. Making appropriate payment at the time of service

PAYMENTS

Best Life Wellness LLC accepts payments by credit card, debit card, check, and cash. In addition to the billed amount, there will be a $25 fee for each check returned for insufficient funds.

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES

All co-payments, co-insurance, and deductibles must be paid at the time of service. These payments are part of your contract with your insurance company. Failure to collect these payments from patients can be considered fraud. Please help us in upholding the law by making these payments on each visit.

SELF-PAY POLICY

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating in their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients are required to pay in full for the cost of the office visit before services are rendered. Payment for any charges accrued during the visit (e.g. laboratory testing, medication administration, etc.) will be collected at check-out.

INSURANCE POLICY

Best Life Wellness, LLC participates with most insurance plans. It is the patient's responsibility to verify if Best Life Wellness, LLC is in-network prior to receiving services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If a service is provided that is not covered by insurance, the patient is responsible for payment at the time of service or upon denial of coverage.

We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

SPECIALTY SERVICES

We may offer specialty services requested by our patients. Specialty offerings will not be billed to insurance but charged as an affordable cash price. These specialty services must be paid for at the time of service. Specialty services include services such as: injections (lipotropic, vitamin, hormones, etc.), aesthetics (neuromodulators such as Botox, body sculpting, etc.), DOT physicals, and prescriptions requested outside of an office visit.

WORKERS COMPENSATION POLICY

Patients needing workers compensation should contact their human resources department prior to scheduling an appointment. Employers may require patients to use a particular healthcare provider.

Patients are responsible for providing accurate information to facilitate billing if the employer or workers compensation carrier is responsible for payment.

Payment for services covered under workers compensation are accepted per contracted rates based on the mandated state fee schedule. If payment is denied by workers compensation, the patient will become responsible for the balance of services. Payment is due within ten (10) days of a workers compensation payment denial.

PAYMENT PLANS
It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. If you are experiencing hardship, please reach out to us to set up a payment plan.

OVERDUE AND CREDIT BALANCES
All overdue patient balances will be sent to collections after 120 days. All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.

CUSTODY AGREEMENTS FOR MINORS
The parent or guardian who accompanies a child into our office will be held financially responsible at the time of service, regardless of policyholder for any billed insurance. Best Life Wellness, LLC has no authority to enforce compliance or to act as a mediator between the parties when there are provisions in a custody decree.

ADMINISTRATIVE FORMS
Forms requiring completion by a healthcare provider (i.e. FMLA, life insurance, wellness forms, employer forms, DMV, etc.) will be subject to a $25 service fee per form. Payment is required prior to the completion of any form. We cannot complete forms requiring medical information or medical decision-making if it has been more than 30 days since your last appointment; exceptions may be made on a case-by-case basis. Please allow at least 5-10 business days for us to complete forms. This does not apply to forms required for the following appointment types when the forms are completed during the visit: DOT physicals, sports physicals, employment examinations; school or job specific forms given to the provider after the visit are subject to the abovementioned fee(s).

MISSED APPOINTMENTS
We understand that scheduling conflicts or unexpected circumstances may occur from time to time. Please call to reschedule or cancel at least 24 hours prior to your appointment. For Monday appointments, any notification after the close of business on Friday will be considered less than 24 hours. No-show appointments will be billed $50 for new patient appointments and $20 for established patient appointments. No-show fees must be paid prior to next scheduled visit.

It is important to keep your scheduled appointment to ensure that you receive timely refills. If you miss your appointment and require refills prior to your next appointment, you will be charged a prescription fee of $10. This fee is not billed through insurance. Repeated no shows or cancellations will result in a denial of refills.

WELLNESS BENEFITS
Please notify staff at check-in if the visit will be covered under a wellness benefit through insurance. Wellness benefits are very specific and limited to well care only. Any chronic or other conditions addressed within the wellness visit (including medication refills) are not covered under the wellness benefit and may be billed separately.

LABORATORY SERVICES
Best Life Wellness offers many diagnostic labs in our office, however some services require that specimens be sent to an outside laboratory for processing. Best Life Wellness often uses LabCorp, Self Regional Healthcare, Medical Diagnostics Laboratory, and others based on need and proximity to patients. If insurance requires use of a particular lab, please disclose that prior to any specimen collection. Best Life Wellness does not bill for diagnostics completed by outside facilities. Patients will receive separate bills from the laboratory and are responsible for payment of all laboratory services not covered by insurance. Questions regarding laboratory billing should be directed to the laboratory that sent the bill.

_____ _____
Patient Signature Date

_____ _____
Relationship to Patient Printed Name (if other than patient)