KEN STARR MD
WELLNESS GROUP

107 Nelson Street, Arroyo Grande, CA 93420
(805) 242-1360 Sunday through Friday 9am-5:30pm

RECOVERY
NEW PATIENT INTAKE and SCREENING FORM

Name:_____ Male/Female D.O.B._____

Race/Ethnicity (data collection purposes/optional): _____

(if requesting a Verification of Insurance Benefits) **Social Security Number: _____**

Cell phone: _____ Do you text at this number ( )Yes ( )No
Is it ok to leave a voice message stating who we are at this # ( )Yes ( )No

Email: _____

Home phone: _____ Cell phone: _____

Mailing Address: Street_____
City_____
Zip_____

How did you hear about us? _____

In case of an emergency please contact:

Name: _____

Relationship: _____

Phone: _____

PRE-TREATMENT SURVEY

Please rate the intensity of your symptoms:

0…..1 (hardly noticeable)...2...3….4...5 (bearable)...6...7...8...9...10 (unmanageable)

MOOD DISTURBANCE = _____

CRAVINGS = _____

WITHDRAWAL = _____

Overall, how have you felt over the past week?

0…...1 (Horrible)....2…3…4...5 (OK)..6...7…8...9…10 (Strong and Hopeful)

How confident are you about recovery?

0….. 1 (not confident)....2…3…4...5 (somewhat confident)..6...7…8...9…10(Extremely confident)

CLIENT HEALTH QUESTIONNAIRE

Question	Yes	No	If 'yes' please explain/give details
Have you ever had a heart attack or any problem associated with the heart?			
Are you currently experiencing chest pain(s)?			
Do you have any serious health problems or illnesses (such as tuberculosis or pneumonia) that may be contagious to others around you?			
Have you ever tested positive for tuberculosis?			
Have you ever been treated for HIV or Aids?			

Question	Yes	No	If 'yes' please explain/give details
Have you ever been tested for sexually transmitted diseases?			
Have you had a head injury in the last six (6) months?			
Have you ever had a head injury that resulted in a period of loss of consciousness?			
Have you ever been diagnosed with diabetes?			
Do you have any open lesions/wounds?			
Have you ever had any form of seizures, delirium tremens or convulsions?			
Do you use a C-PAP machine or dependent upon oxygen?			
Have you ever had a stroke?			
Are you pregnant?			Trimester: Complications?: Pre-Natal care?:
Have you ever been pregnant?			# of pregnancies: # of live births:
Do you have a history of any other illness that may require frequent medical attention?			

Have you ever had blood clots in the legs or elsewhere that required medical attention?			

Question	Yes	No	If 'yes' please explain/give details
Have you ever had high-blood pressure or hypertension?			
Do you have a history of cancer?			
Do you have any allergies to medications, foods, animals, chemicals, or any other substance?			
Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation?			
Have you ever been diagnosed with any type of hepatitis or other liver illness?			
Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease?			
Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis?			
Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder?			
Do you have any of the following; arthritis, back problems, bone injuries, muscle injuries, or joint injuries?			

Question	Yes	No	If 'yes' please explain/give details
Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen?			
Do you take over the counter digestive medications such as Tums or Maalox?			
Do you wear or need to wear glasses, contact lenses, or hearing aids?			
Please describe any surgeries or hospitalizations due to illness or injury that you have had in the past:			
When was the last time you saw a physician and/or psychiatrist? What was the purpose of the visit?			

SUBSTANCE USE:

33. In the past **seven days** what types of drugs, including alcohol, have you used?
Type of Drug = _____
Route of Administration = _____

34. In the past **year** what types of drugs, including alcohol, have you used?
Type of Drug = _____
Route of Administration = _____

35. Do you take any prescription medications including psychiatric medications?
Type of Drug = _____
Route of Administration = _____

MENTAL/EMOTIONAL

Question	Yes	No	If 'yes' please explain/give details
Are you currently feeling down, depressed, anxious or hopeless?			
Are you currently receiving treatment services outside of Ken Starr for an emotional/psychiatric diagnosis?			
Over the last 2 weeks, have you felt nervous, anxious, or on edge?			
Did you feel like you were unable to stop or control your worrying?			
Over the last 2 weeks, have you had thoughts of suicide or thought that you would be better off dead?			
If yes to the above question, do you have a plan for how you would harm yourself?			
Have you attempted suicide in the past two (2) years?			
Have you ever harmed yourself/others or thought about harming yourself/others?			
Are you currently feeling that you're hearing voices or seeing things?			
Have you ever been in a relationship where your partner has pushed or slapped you?			

Question	Yes	No	If 'yes' please explain/give details
Have you received alcoholism or drug abuse recovery treatment services in the past?			Type of Recovery: ❏ Outpatient ❏ Residential ❏ Detoxification
Name of Previous Treatment Facility: Dates of Previous Treatment: Was Treatment Completed?:			
Have you ever been treated for withdrawal symptoms?			

I declare that the above information is true and correct to the best of my knowledge:

Client Signature **Date**

ARBITRATION AGREEMENT

I understand that any dispute between myself and Ken Starr MD Wellness Group, including without limitation, employees, independent contractors, agents, and/or other service providers (collectively Ken Starr MD Wellness Group), regarding services you were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this arbitration agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is the intention of the parties involved that this arbitration agreement shall cover all claims or controversies, whether in tort, contract or otherwise, and shall bind all parties whose claims may, among other things, arise out of or in any way relate to treatment or services provided or not provided by Ken Starr MD Wellness Group to you. A demand for arbitration must be communicated in writing by US mail, postage prepaid, to all parties, describing the claim against Ken Starr MD Wellness Group, the amount of damages sought, and your name, address and telephone number, and if applicable, your attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. I understand I shall pursue my claims with reasonable diligence, and the arbitration shall be

governed pursuant to the Code of Civil Procedures 1280-1295 and the Federal Arbitration Act (9 USC 1-4). I intend this arbitration agreement to cover all services rendered by Ken Starr MD Wellness Group not only after this agreement is signed, but also before it was signed. I understand this agreement may be revoked by written notice within 30 days of signature and if not revoked will govern all services received. In the event any provisions of this agreement are declared void and/or unenforceable, such provisions shall be deemed severed therefrom and the remainder of the agreement shall be enforced in accordance with California law. **By signing this contract I am agreeing to have any issue of medical malpractice decided by neutral arbitration and I am giving up my right to a jury or court trial.**

_____ _____

Client Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Printed Name **Date**

_____ _____

Patient Signature **Date**

Telebehavioral Health Informed Consent

As a patient receiving behavioral services through telebehavioral health technologies, my health care practitioner has explained how telehealth is performed and how it will be used for my treatment. I understand:

____ Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location. The interactive technologies used in telebehavioral health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:
___ Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the date to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:
____ This service is provided by technology (including but not limited to video, phone, text, apps, and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:
____ I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. Telehealth will not work effectively without wifi and the appropriate bandwidth.

Exchange of Information:
____ The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery. During my behavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:
____ If a need for direct, in-person services arises, it is my responsibility to schedule an in-person appointment at Ken Starr, or to contact practitioners in my area. I understand I may utilize my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office.

Self- Termination:
____ I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services and benefits.

Risks of Technology:
____ These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:
____ My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

Emergency Protocol:
____In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means, go to the hospital, call 911, or to involve other persons in my support network: Emergency Contact for behavioral health services _____.

Client Communication:
____ It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
____ I will take the following precautions to ensure that my communications are directed only to my psychologist or other designated individuals on a Release of Information.

Storage
____ My communication exchanged with my practitioner will be stored in the following manner:

- Kareo Electronic Medical Record through Chiron Telehealth.

Law & Standards:
____ The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This Document does not replace other agreements, contracts, or documentation of informed consent.

I have read this document carefully and fully understand the benefits and risks; I unconditionally release and discharge Ken Starr MD Wellness Group from any liability in connection with my participation in telehealth:

_____
Printed Name

_____ _____
Signature Date

Outpatient Admission and Financial Agreement

MEDICALLY NECESSARY LEVEL OF CARE

I understand that I am responsible for fully and honestly reporting my wellness history and current concerns, needs, and behaviors in order to afford a clinically sound assessment and appropriate course of treatment. This includes my commitment to an honest and ongoing report of all prescription and over the counter drugs and alcohol that I am taking. I understand that my assessment has identified the medical necessity of my treatment recommendations. I acknowledge the recommended level of care and understand the program requirements within that level of care in order to achieve maximum progress and stabilization. If at any time, I miss appointments, attend less than the recommended level of care, or request a lower level of care, I am going against medical advice. In addition to regular attendance, Ken Starr MD Wellness Group is strongly encouraging me to attend outside support groups and recreational outlets in order to retain a strong network of natural support for sustained health and wellbeing. I understand that the current level of care I am receiving is dependent upon my current needs assessment and may change due to a relapse or acute episode. If the level of care I require exceeds the scope of the practice, my provider will share external referrals and assist me with transitioning to higher/different levels of care.

PROGRAM COMPLIANCE

My full participation and timely attendance reflects my commitment to improving the quality of my life and wellbeing. I understand that I must abide by this agreement and attend scheduled appointments in order to receive a smooth continuum of services. If I am enrolled in a package program, I must attend all groups and sessions associated with the program in order to retain a 'program completion' status. If I stop attending or have missed services offered within a specified rotation or program cycle, I will receive a notice of pending discharge and will have forfeited any fees paid. I understand that in addition to regular program attendance, I must comply with the program rules within the Collaborative Outpatient Care Agreement to avoid early discharge and referral elsewhere. If at any time, my behavior becomes threatening, abusive, sexually inappropriate, or otherwise hostile and unsafe, I may be discharged early from the program with external referral for continuation of services. If prescribed medications, I agree to take medications as discussed and prescribed by my provider. I will not adjust doses without discussing these changes with my provider. I realize there are serious risks associated with both under and over self-medicating.

CONTACTING YOUR PROVIDER

I understand that my provider may not always be available when I call, but will have a voicemail where I may leave messages and expect a return call. If I am experiencing an emergency, I will contact the nearest emergency room and ask for clinician or doctor on call. If my provider will be unavailable for an extended period of time, I will be provided with contact information for the covering provider. I understand that I may elect to use texting or other telephonic communications (including Google Voice) to communicate with my provider. This form of communication is subject to precautions associated with using an unsecured line. I understand that while cell phones will be password protected, and no data will be stored in an unsecured manner, my confidentiality is still at risk. I understand that my ability to contact my provider via a business cell line is dependent upon proper use, and that any misuse will result in losing this ability. This form of communication may not be used for crisis experiences; I understand that my provider may not be able to answer, and therefore the 24 hour crisis hotline 1-800-838-1381 or emergency medical services should be utilized in those scenarios. I understand that prescription medication refills will NOT be called in after 5pm or during the weekend.

INFORMED CONSENT

I understand that my provider is either licensed/certified in their field or under the supervision of a licensed provider. I consent to collaborative treatment, where my care will be under the supervision of the Medical Director. I consent to follow up contact after treatment, where I may be asked questions regarding symptom improvement or relapse, satisfaction with the services I received, and need for re-engagement in services. I understand I may decline to answer any follow up survey at any time without repercussion.

MEDICAL RECORD

I understand that I have a medical record maintained by Ken Starr MD Wellness Group. I am entitled to receive a copy of my records by giving a verbal or written request and expecting 7-10 days for file preparation. I understand that it is recommended I review my records with my provider in order to have them better explained and understood. I understand that my treatment information will be discussed and shared within the Ken Starr MD Wellness Group clinical team on an 'as needed' and 'minimum information necessary' basis to coordinate care, receive and provide consultation on my treatment needs, and deliver a smooth continuum of care.

CONFIDENTIALITY

I understand that my confidentiality is highly protected, and that I am also bound by HIPAA and 42 CFR Part 2 Federal Regulations to never disclose who attends treatment or what is discussed in program sessions. I understand that I must protect my own confidentiality by avoiding conversations in the lobby, hallways, and other general public areas. I understand that my attendance in treatment, treatment records, and the communication between myself and my treatment providers are protected by HIPAA and 42 CFR to the degree that Ken Starr MD Wellness Group may not disclose such information without my written and/or verbal release. I understand that exceptions to the protection of my health information include the following: my written consent to a specific party, a court order, my own medical emergency requiring disclosure to medical professionals for appropriate emergency care, internal research/audit/program evaluation performed by qualified staff, a crime committed by myself or threatened by myself on the premises or against Ken Starr MD Wellness Group employees, suspicion of elderly or child abuse based upon my statements or actions, and statements I make suggesting my intent to cause imminent serious harm or threat of serious harm to myself or others. If a situation occurs that warrants a potential exception to my privacy and confidentiality, my clinical team will make every effort of discussing the event with me prior to disclosure, if able. I understand that violation of the Federal Law and regulations by Ken Starr MD Wellness Group is a crime and suspected violations may be reported to appropriate authorities in accordance with Federal regulations. I am aware that a copy of the Federal regulations is kept by Ken Starr MD Wellness Group and I may ask my provider to review the regulations if I have any questions.

DRUG SCREENING AND PARAPHERNALIA

I understand that I may not be under the influence or have illicit drug paraphernalia on my person or on the premises in order to receive services. I also understand that if I am enrolled in a recovery program, drug and alcohol testing are required components of my treatment to ensure gains in recovery are validated and my level and plan of care is appropriate/medically necessary. I understand the urine drug screen (UDS) evaluates a sample of my urine by examining the appearance, concentration and content. I understand the blood alcohol content (BAC) test evaluates a sample of my breath to determine levels of ETOH. I understand the results of drug screens will be used to evaluate the validity of reports of sobriety, abstinence or relapse. The results may also be used in medication management or mental health services to evaluate the validity of reports of prescription use/misuse, or evaluate toxicology issues that influence the prescribing of medications. I am aware Ken Starr MD Wellness Group has a Qualified Service Agreement with Quest Diagnostic, a toxicology company that provides UDS supplies, examines the UDS, and provides a report on UDS results. Quest Diagnostic is bound by HIPAA and 42 CFR Part 2 to maintain my confidentiality in the receiving and testing of UDS submissions. They will only disclose results to Ken Starr MD Wellness

Group. I understand drug screens are considered medically necessary for my course of treatment and if enrolled in recovery services, I must be prepared to give a drug screen anytime I am at Ken Starr MD Wellness Group receiving services. I understand that my refusal to give a sample in the prescribed time or fashion, including tampering with the collection, storage and testing process will be considered non-compliance and may be assumed the sample was positive for chemical use. I am aware that if the specimen is needed for legal compliance and documentation admissible in court, it will be given in observance of same sex staff, unless an oral swab is used.

GRIEVANCE PROCESS

I understand I may submit verbal or written grievances to my assigned counselor or any member of office staff at any time. I am aware grievance forms are available in the front lobby for personal or anonymous submission, or I may send a note of complaint at any time to info@kenstarrmd.com or 107 Nelson Street, Arroyo Grande, CA 93420. I may expect a verbal or written response to any grievance I have submitted within 48 hours of submission; I have the right to appeal the response with the Executive Director or President/CEO through the same grievance process and will be notified of the results of the appeal within 48 hours. I understand any retaliation in response to my grievance or appeal is strictly prohibited and will not be tolerated.

VIDEO SURVEILLANCE

I understand that as a facility safety and security precaution, Ken Starr MD Wellness Group utilizes non-audio recording security cameras in all common areas, including spaces where group sessions are facilitated. Recordings would only be used in the case of security or safety breach related to the premises.

FINANCIAL AGREEMENT

I understand I am financially responsible for the Ken Starr MD Wellness Group outpatient services defined in this agreement*. I attest that I have been informed of the importance of not being under the influence of any alcohol or drugs while agreeing to treatment. I understand that while Ken Starr MD Wellness Group staff consistently assesses my comprehension and competency to agree to services and fees, they cannot provide an absolute guarantee of competency. For this reason, it is critical that I am honest and forthcoming with staff as to whether my services should be rescheduled due to my inability to comprehend. ***Less than 24 hour cancellation: Patient will be charged the missed appointment fee <u>prior</u> to scheduling a future service. Patient initial next to ordered service.**

OUTPATIENT SERVICES *Cash Pay Adjustment Prices			
	New Patient Clinical Assessment with Clinician *60 min.	250	
	New Patient Medical Assessment with Physician, Psychiatric Nurse Practitioner, Naturopathic Doctor *(Medication Prescribing, Health/Hormone, Chelation)* *60 min.	250	
	Established Patient Follow-up with Physician *20 min.	135	
	Psychiatric Follow-up with PNP *30 min.	135	
	Established Patient Follow-up with Naturopath *30 mins	175	

	SAP Evaluation for DOT Employees *(Clinical Assessment, Collateral Review, 2 Urine Drug Screens and/or BAC Tests, DOT paperwork, Treatment Coordination, Follow up Appt)*	495	
	Verification of Benefits	25	
	Prescription Calls (patient/pharmacy)	30	
	Drug and Alcohol Testing	45	
	Court Admissible Drug and Alcohol Testing	195	
	Individual Counseling Session *60 min.	115	
	Family Therapy/Couples Session *90 min.	$150	
	Group Session	50	
	Reports/Letters	30	
	Case Management - under 20 mins complimentary, bill is incurred over 20 mins and up to 1 hour	95	
	Lab or Imaging Order and Interpretation	200	
	START DATE: _____ **PAYMENT PLAN:**		

OUTPATIENT PACKAGES ***Cash Pay Adjustment Prices**			
	NAD+ (Brain Restoration) PHP (Partial Hospitalization Program): Full Day Group Counseling Sessions, Drug screening, catered lunch, Nursing Detox services, physician supervised care, and NAD infusion.	1,300 per day	*same price for NAD for detox only, without programming
	PHP PROGRAM ONLY (Partial Hospitalization Program): Full Day Group Counseling Sessions, nursing and physician care, Drug screening, catered lunch	700 per day	
	IOP (Intensive Outpatient Program) 6 week expiration: 3 weekly Group Counseling Sessions, 1 weekly Individual Counseling Session, Drug screening	1,800 6 weeks	Adding Family ☐ Adding Individual Session ☐
	OP (Outpatient Program) 12 week expiration: 1 weekly Individual Counseling Session, 1 Group Counseling Session weekly	1,900 12 weeks	Adding Family ☐ Adding Individual Session ☐

START DATE: _____
PAYMENT PLAN:
***For program packages, a deposit equivalent to the first day is required prior to day of appointment. This deposit and any package payments may be transferable to a different day with more than 24 hours notice, and expires (non-refundable and non-transferrable) after 3 months. This fee is non-refundable with less than a 24 hour cancellation notice.**

WELLNESS SERVICES		
SHOTS	**IV INFUSIONS**	**SERVICES**
B12 Shot $25	Original Meyer's Push $110	NAD+ Brain Restoration Therapy $1,100
Skinny Shot $40	Nourish $145	Chelation Therapy $250
Immunity Boost $40	C Power $195	Nutrition Coaching $75
Basic IV Hydration (1st liter of fluid $95, 2nd liter $50)	Fountain of Youth $55	Neurotransmitter Testing $218
	Purify $145	Ketamine Therapy 40 min. infusion $450 80 min. infusion (pain indication) $700 2 infusion treatment plan $800 4 infusion treatment plan $1400 6 infusion treatment plan $1900
Bug Off $145	Party Recovery $125	
Slim Down $1450	Chill Out $145	
Added push to IV: B12 $20 Glutathione $40	Basic HCG Weight Loss Package $950 Premium HCG Weight Loss Package $1,160	Men's Health (Testosterone Replacement Therapy) *assessment starting at $250

START DATE: _____
PAYMENT PLAN:
***For NAD, Ketamine, and Chelation infusions, a deposit equivalent to the first infusion is required prior to day of appointment. This deposit may be transferable to a different day with more than 24 hours notice, and expires (non-refundable and non-transferrable) after 3 months. This fee is non-refundable with less than a 24 hour cancellation notice.**

PAYMENT & REFUND POLICY

I understand that as a Ken Starr MD Wellness Group patient, I am required to maintain an active credit card on file. I understand that my credit card will be used for appointment and service fees due to late cancellation and/or no-shows. If I am paying with cash only and not billing insurance, I understand that fees are due prior to the delivery of services. If I am paying with a package rate, payments will need to remain current in order to continue receiving seamless services. I understand that I must attend services within the time frame/package I have agreed to. I understand that fees are not negotiable and that failure to pay may result in discontinuation of services with a referral. Similarly, I understand that I will

not be eligible to receive letters or reports of treatment compliance or completion without a paid in full balance. I understand that I am responsible for payment for all services rendered and will inform my therapist or staff member when I am unable to continue paying for treatment in order to discuss alternative payment options. I understand that there is no refund for services once services have begun and are honored by Ken Starr MD Wellness Group. I also understand that I will not be provided a refund for services if I arrive for such services in a violent, agitated, intoxicated or otherwise under the influence state. If I have paid for services that I cannot attend/receive due to my own personal circumstances, I will not be entitled to a cash refund but I will be allowed to credit this payment toward future services. The credit for future services will expire 6 months from original date of purchase. If I did not receive services due to the inability of the practice to provide, I will be entitled to a credit or cash refund.

INSURANCE COVERAGE

I understand that Ken Starr MD Wellness Group is out of network for all insurances at this time. As a courtesy per request, and with a signed release of information, they will attempt to get authorization for payment and bill my insurance for services rendered. I understand I am responsible for payment for all services rendered by Ken Starr MD Wellness Group, as insurance reimbursement cannot be guaranteed. If my insurance does not cover all or part of my care, I may request a 'superbill' to advocate directly to my insurance for payment reimbursement. If my insurance policy requires 'prior authorization' in order to receive services, an office staff will assist me in acquiring pre-authorization with the understanding that Ken Starr MD Wellness Group will not be held liable for future insurance claims of reimbursement. I understand I will receive a billing statement each month from Ken Starr MD Wellness Group reflecting any balance due on my account. I understand Ken Starr MD Wellness Group will not accept responsibility for collecting insurance claims or negotiating a settlement on a disputed claim. I understand that failure to pay Ken Starr MD Wellness Group may jeopardize my insurance benefits and ability to receive services. I understand that since I am the individual receiving services, I am financially liable. I acknowledge that fees within my Outpatient Care Agreement reflect cash rates billed to the patient; they may not reflect the true and actual cost of service reflective of industry standards and customary fees. I understand that the cost to insurance may exceed the cash price discount I pay; in such event I will complete a financial waiver to resolve the difference. I understand that there is a 10% fee for handling and distributing insurance reimbursement payments. Reimbursement after insurance, if any, will be based upon the allowable amount listed on the Explanation of Benefits. I may choose to accept a 'superbill' and bill my insurance directly in order to avoid such fees; in this event I would be a 'cash pay' only client.

DELINQUENCY

I understand that Ken Starr MD Wellness Group will make several attempts to collect payment. I will be notified by telephone and letter once my account becomes delinquent after 30 days. I understand that if my account is more than 90 days in arrears and no attempt has been made on my part to return calls or set up a payment plan, my account will be terminated and sent to a collections agency. I understand that a re-billing fee in compliance with California state law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees.

LATE CANCELLATIONS

I understand that I must call to cancel an appointment 24 hours or more in advance, otherwise I must pay the appointment fee I missed in order to schedule future appointments. If I have paid for a program package, a less than 24 hour cancellation will result in the service appointment being counted as 'used'. I will not be allowed to recover a missed appointment if I did not follow the 24 hour cancellation requirement. I understand that if my credit card is on file, it will be used for payment of services scheduled that do not receive a 24 hour or more cancellation.

ARBITRATION AGREEMENT

I understand that any dispute between myself and Ken Starr MD Wellness Group, including without limitation, employees, independent contractors, agents, and/or other service providers (collectively Ken Starr MD Wellness Group), regarding services you were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this arbitration agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is the intention of the parties involved that this arbitration agreement shall cover all claims or controversies, whether in tort, contract or otherwise, and shall bind all parties whose claims may, among other things, arise out of or in any way relate to treatment or services provided or not provided by Ken Starr MD Wellness Group to you. A demand for arbitration must be communicated in writing by US mail, postage prepaid, to all parties, describing the claim against Ken Starr MD Wellness Group, the amount of damages sought, and your name, address and telephone number, and if applicable, your attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. I understand I shall pursue my claims with reasonable diligence, and the arbitration shall be governed pursuant to the Code of Civil Procedures 1280-1295 and the Federal Arbitration Act (9 USC 1-4). I intend this arbitration agreement to cover all services rendered by Ken Starr MD Wellness Group not only after this agreement is signed, but also before it was signed. I understand this agreement may be revoked by written notice within 30 days of signature and if not revoked will govern all services received. In the event any provisions of this agreement are declared void and/or unenforceable, such provisions shall be deemed severed therefrom and the remainder of the agreement shall be enforced in accordance with California law. **By signing this contract I am agreeing to have any issue of medical malpractice decided by neutral arbitration and I am giving up my right to a jury or court trial.**

I, _____, have read and fully understand Ken Starr MD Wellness Group's Outpatient Care Agreement. I am agreeing to the policy that has been thoroughly explained to me, with opportunity for questions and answers. All questions or concerns have been answered to my satisfaction. I have been provided with a copy of the following Outpatient Care Agreement.

_____

Client Signature **Date**

_____

PRINTED NAME **Date**

Recovery patients: BAC test on _____= _____ Staff Initials _____

_____

Support Partner and/or Person with Financial Responsibility **Date**

Witness

Name of Person with Financial Responsibility: _____

Phone Number _____

Address _____

_____

Provider Signature **Date**

RELEASE OF INFORMATION

Date of Authorization: _____

I, _____
Client Name **Date of Birth**

authorize Ken Starr MD Wellness Group, representative _____and
Employee Name

Name of Agency and/or Person:		**Home/Business Phone:**	
Address:		**Cell Phone:**	
		Fax:	

To communicate with and disclose to one another the following information verbally, written, and/or facsimile (Client MUST initial each category that applies):

	My name and other personal identifying information		Treatment plan
	Initial assessment evaluation results and history		Progress report(s) and compliance
	Date of admission/interpretive summary		Toxicology results
	Date of transition/discharge and transition/discharge summary		Continuing care plan
	Significant information for screening and treatment		Medical emergencies
	Attendance in Treatment Only		Other:

The disclosure of the information in this consent is for the purpose of (Client MUST initial category that applies):

	Continued treatment		Personal use
	Legal		Medical treatment
	Other (Must indicate):		

I understand that the information to be disclosed includes information pertaining to drug/alcohol abuse, treatment and rehabilitation. _____ (Client MUST initial)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R., Parts 160 and 164, cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____.

(MUST have specification of the date, event, or condition upon which this consent expires)

I understand that generally Ken Starr MD Wellness Group may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Signature of Client:		**Date:**	
Witness:		**Date:**	