WELLNESS
NEW PATIENT INTAKE FORM

Name:_____ **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: _____

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**

Outpatient 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.	295	
	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	95	

	incurred over 20 mins and up to 1 hour		
	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. With more than a 24 hour cancellation notice, refunds may be subject to an 8% credit card processing fee.**		

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 Ketamine Infusion Session(40 min) : $450 Package of 6 sessions: $2300 4 hour Ketamine Infusion for Pain: $1600 5 Day Pain Protocol Package: $7900
Bug Off $145	Party Recovery $125	
Slim Down $1450	Chill Out $155	
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.With more than a 24 hour cancellation notice, refunds may be subject to an 8% credit card processing fee.**

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 (does not apply to program packages). 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 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 may be offered; in such event I may 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.

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**

_____

Provider Signature **Date**