Institute for Progressive Medicine
4 Hughes, Suite #175 Irvine, CA 92618 Tel: (949) 600-5100 Fax: (949)600-5101
iprogressivemed.com hormonepellets.com

Medical Doctor Return Patient Packet

** IMPORTANT - PLEASE BRING COMPLETED FORMS TO YOUR NEXT APPOINTMENT **

Full Legal Name_____

Nickname_____

Primary Reason for Visit_____

How did you hear about us? _____

Birth Date_____/____/_____ Age_____ □ Female □ Male Race_____ Ethnicity_____

Mailing Address_____

City _____State_____ Zip _____

Email Address_____

Primary phone (_____) _____-_____ □ home □ cell □ work

Secondary phone (_____) _____-_____ □ home □ cell □ work

Employer phone (_____) _____-_____

Occupation_____ Employer_____

Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse/Partner Name_____ Spouse/Partner Birth Date____/____/____

Who may we contact in the case of an emergency?

Name_____Phone (_____) _____-_____ Relationship_____

(Minors under 18) Name of Guardian_____ Tel (_____) _____-_____

Check below if you agree to share personal information with a named individual:

☐ I consent to have my personal medical and billing information shared with the person listed below.

Name _____ Relationship _____ Phone (_____) _____-_____

Patient Contact Information

Staff at IPM may contact you by mail, email, text or telephone to relay important information about your health such as appointment reminders, lab results, physician recommendations and prescription information.

IPM does not accept any medical insurance plans for services. We currently accept cash, check, most major credit cards, and CareCredit as valid forms of payment. Payment is due at the time of service.

I certify the information above is true and correct to the best of my knowledge and I will notify IPM of any changes in the status of the above information.

Signature: _____ Date: _____

Parent signature (if minor) _____ Date: _____

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Statement of Patient Awareness and Responsibility

- I am aware that any therapy, no matter how well designed and carried out, may fail to alleviate my symptoms and improve my health.
- I agree to make every effort to pursue the program mutually agreed upon with my physician.
- I expect to be informed of those therapies most relevant to my condition, both conventional and alternative, realizing that I have the choice to accept, refuse or terminate them at any point.
- I understand that unforeseen difficulties may arise in the course of my treatment.
- I am responsible to seek professional medical attention from a medical or naturopathic doctor employed at the Institute for Progressive Medicine, or another facility for any worsening of my condition, including consideration of hospitalization, invasive procedures or treatment in the emergency room.
- I am aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- I am aware that I will not be told to avoid seeing other physicians. I understand that I may be referred to another physician for treatment and that other options of medical care are available to me.
- I understand that IPM is not contracted with any health insurance provider and does not have an active billing department or billing staff members. I understand that IPM staff are not authorized to answer specific questions about coverage for services or therapies received at IPM and cannot guarantee a specific medical insurance provider will cover the codes provided on superbills when requested.

I have read, understand and agree to **IPM's Notice of Health Information Practices and Statement of Awareness and Responsibility** above.

Print name: _____

Signature: _____ Date:____/____/____

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IPM Office Policy

We recognize and appreciate that health care can involve a major financial commitment. We aim to provide you with effective services and treatments. As a patient of the Institute for Progressive Medicine, you are responsible for the total charges incurred for each visit or any balances. Charges for cash services are to be paid at the time of each visit. All patients are required to complete the following forms: **1)** IPM New Patient Packet, **2)** IPM Physician-Patient Arbitration Agreement **3)** IPM Patient Private Contract. **These documents must be completed and signed before a patient may see a doctor or receive any service at IPM.**

_____

Payment for all services is due at the time of service. You have the right to refuse any service recommended by our staff for any reason. We accept cash, check, most major credit cards, and Care Credit as valid forms of payment. There will be a $35.00 charge for any returned checks.

_____

IPM does not accept medical insurance plans for services rendered at our facility. If you have any questions about our payment policy, please contact reception. If you have private insurance our office staff may provide you with the necessary paperwork (super-bill, procedure and diagnosis codes) that you will need to submit for reimbursement to your insurance company. Most insurance companies do not cover integrative or alternative medical services. You have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. Unfortunately, due to Medicare regulations, IPM is unable to provide superbills or billing assistance for reimbursement for patients who have Medicare or Medicare Advantage plans.

_____

We are committed to providing timely and exceptional care to our patients. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call reception at least 24 hours in advance of your appointment for any changes or cancellations. To change or cancel a Monday appointment, please call us before 12:00pm on Friday.** If prior notification is not given, there will be a **$50.00** charge missed appointments or appointments cancelled without enough notice.

We make every effort to see all scheduled appointments; however, we reserve the right to reschedule your appointment if you arrive more than 15 minutes after your scheduled appointment time, or in case of emergency.

I have read, understand, and agree to the **IPM Office Policy** above.

Print name: _____

Signature: _____ Date:____/____/____

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IPM Prescription Medication Policy

Prescription medication may be recommended and prescribed by a physician at the Institute for Progressive Medicine. All prescription medications present a potential risk of side effects which may or may not be noticeable to the patient. Side effects may be compounded or worsened when using multiple medications. For this reason, their use must be monitored by a physician. Our policy on prescription refills exists to comply with federal drug regulations and to protect the health of our patients.

- No patient will receive a prescription refill unless he or she has been seen in person by a physician at the Institute for Progressive Medicine within the last 12 months. If you have not been seen by a physician at IPM within this time, you will be required to be seen in-person by an IPM physician before a refill can be granted by our staff.
- Under certain circumstances our physicians may require a patient to be seen in-person before a refill can be given, even if it has been 6 months or less since the last office visit.
- When requesting a refill, please do not call our office. Instead, request that your pharmacy fax a prescription refill request to us at 949-600-5101. Allow up to 72 hours for our medical staff to respond to refill requests from your pharmacy.

Laboratory Billing Information

Our doctors may order laboratory or other diagnostic testing for you. Most testing will be sent to an outside laboratory for processing and billing. It is your choice to receive laboratory testing recommended by your doctor. The fee for collection of samples at IPM to be sent to an outside laboratory is $30.

Outside laboratories are usually contracted with most major insurance plans, so they may bill your insurance for you. Please make sure you provide your current insurance information to our staff so that it can be forwarded to the lab for billing purposes.

It is the patient's responsibility to understand their individual insurance policy and coverage. If you are unsure about coverage for a particular test or procedure, please contact your insurance company directly.

I have read, understand, and agree to the **IPM Prescription Medication and Laboratory Billing Policy** above.

Print name: _____

Signature: _____ Date:____/____/____

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IPM Patient Private Contract
Updated for Jan 1, 2025

This contract is made between physicians at Institute for Progressive Medicine, A Professional Medical Corporation (referred to as "IPM Physicians") and any patient seeking treatment at IPM (referred to as "Patient"). If as a patient you have any questions about this contract, please contact IPM reception.

- Patient has been informed that IPM Physicians have voluntarily opted out of the Medicare program effective January 1, 2019 for a period of at least two years and are not excluded from participating in Medicare Part B under Sections 1128, 1156 or 1892 or any other section of the Social Security Act. This contract is valid from the date signed and is effective for the entire duration of the opt-out period.

- Patient or his or her legal representative, accepts full responsibility for payment of charges for all services furnished by IPM Physicians. He or she further understands that Medicare limits do not apply to what IPM Physicians may charge for items or services furnished at IPM.

- Patient or his or her legal representative agrees not to submit a claim to Medicare or to ask IPM Physicians to submit a claim to Medicare.

- Patient or his or her legal representative understands that Medicare will not pay for any items or services furnished by IPM Physicians.

- Patient agrees to this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from a physician and or practitioner who has not opted out of Medicare. This contract does not prevent Patient from seeking Medicare-covered services furnished by other physicians or practitioners who have not opted out of Medicare.

- Patient or his or her legal representative understands that Medigap plans, Medicare Advantage programs and other supplemental insurance plans may not pay for items and services not paid for by Medicare.

- Patient or his or her legal representative acknowledges that he or she is not entering into this contract during a time when Patient is requiring emergency or urgent care services.

- Patient agrees to reimburse IPM Physicians for any costs and reasonable attorney's fees that may result from violation of this contract by Patient and his or her legal representatives.

(Continued on next page)

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- Patient or Patient's legal representative has had the opportunity to read, understand and ask questions regarding this contract before signing.

- Patient or his or her legal representative acknowledges that a copy of this contract has been made available to him or her before items or services are furnished under the terms of this contract. This contract supersedes (replaces) any previous agreements between Patient and IPM Physicians regarding Medicare.

- IPM Physicians will retain this original contract for the duration of the opt-out period and will supply a copy of this contract to Centers for Medicare Services (CMS) upon request.

_____ _____
Provider Signature Date

_____ _____
Provider Signature Date

_____ _____
Provider Signature Date

_____ _____
Patient Full Name (please print) Date of Birth

_____ _____
Telephone E-mail Address

_____ _____
Patient or Legal Representative Signature Date

_____ _____
Witness Date